

THE UTILISATION OF THE MEMORY BOX AS A MEDIUM IN GESTALT PLAY  
THERAPY WITH AIDS ORPHANS IN MIDDLE CHILDHOOD

BY

FAYE MARGARET GOUGH

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SUPERVISOR: DR C.H.M. BLOEM

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## DECLARATION

STUDENT NUMBER: 642-583-6

I HEREBY DECLARE THAT "THE UTILISATION OF THE MEMORY BOX AS A MEDIUM IN GESTALT PLAY THERAPY WITH AIDS ORPHANS IN MIDDLE CHILDHOOD" IS MY OWN WORK AND THAT I HAVE IDENTIFIED AND GIVEN RECOGNITION TO ALL RESOURCES AND REFERENCES QUOTED.

.....  
FAYE MARGARET GOUGH

.....  
DATE

I WOULD HEREBY LIKE TO EXPRESS MY GRATITUDE AND APPRECIATION TO  
THE FOLLOWING PEOPLE:

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## ABSTRACT

This study aimed to test the efficacy of the memory box as a medium in Gestalt Therapy, specifically within a therapeutic group with AIDS orphans in the middle childhood phase of development. The aim was to explore and describe the utilisation of the memory box, as a medium for telling one's story, within the safety of the Gestalt play therapy group. It was felt that the increased self-awareness fostered by belonging to a supportive group could enhance self-concept. The research included qualitative and quantitative data. Theoretical and the meta-theoretical assumptions affecting children, in the middle childhood phase, orphaned through HIV/AIDS, were reviewed. The group sessions were described and the data obtained from the pre and post-test was graphically illustrated. The information was then compared to ascertain whether the objectives had been met. Results show that the memory box, used in Gestalt play therapy groups, with AIDS orphans was effective.

## KEY TERMS:

Memory box; Gestalt play therapy; AIDS orphans; Middle childhood development phase; Self concept; Self esteem; Field theory; Awareness; Grief; Unfinished business.

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# **CHAPTER ONE**

## **What AIDS Can't Do**

AIDS is  
SO LIMITED  
It cannot cripple  
LOVE  
It cannot shatter  
HOPE  
It cannot corrode  
FAITH  
It cannot take away  
PEACE  
It cannot destroy  
CONFIDENCE  
It cannot kill  
FRIENDSHIP  
It cannot shut out  
MEMORIES  
It cannot silence  
COURAGE  
It cannot invade  
THE SOUL  
It cannot reduce  
ETERNAL LIFE  
It cannot quench  
THE SPIRIT

**OUR GREATEST ENEMY IS NOT  
DISEASE BUT DESPAIR**

(Anon)

## 1.1 Introduction

AIDS, a growing worldwide phenomenon, has had a profound effect on family life in South Africa. Children in middle childhood are increasingly finding themselves without parents or caregivers. Without this vital support structure, these children are experiencing many traumas, leading to a loss of sense of self. A cost effective and practical method of helping these children is to use Gestalt group play therapy.

From a Gestalt perspective, the memory box as a medium, lends itself to facilitating the grieving process by enabling the child to build and preserve her own legacy. "Who am I?" C.S. Lewis said, "There is one thing, and only one in the whole universe which we know more about than that we could learn from external observation. That one thing is ourselves. We have, so to speak, inside information, we are in the know" (Lewis, 1952: 25). However, many people spend a great deal of time in a state of confusion about themselves, consumed by contradictory thoughts, feelings and emotions. Crossley (2000: 3) states that even when we do know how we feel, we are not always sure why we feel that way. Social constructivists study these dilemmas using narrative approaches, emphasising the connection between self and social structures. What is important for this research is that the construction of self is always a temporal process through which we have dialogue with different images of the self taken from the past and future, and mediated by the anticipated responses of significant and generalized others (Crossley, 2000: 13).

Narrative theory of psychology advocates the need to focus attention on human existence as it is lived, experienced and interpreted by each human individual. McAdams (1993: 11) stated that, "If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I too, must know my own story." The memory box is felt to be an age appropriate manner in assisting the AIDS orphan to tell their story, thereby, improving the child's sense of self, aiding the overall development of the AIDS orphan, during the middle childhood developmental phase, by enabling the child to know who she is in the here and now.

## **1.2 Motivation and Problem Formulation for the Study**

Due to an increasing number of orphans in South Africa, mostly due to AIDS, it is necessary to find a cost effective and practical method of delivering therapy to these children. An estimated 18 percent of South African children are orphans. According to the Medical Research Council, at least 5.7 million children could lose one or both parents to AIDS by 2015. Gestalt group play therapy, incorporating the memory box as a medium for reconstruction of life stories, has the potential to be a quick and effective means of reaching these children. The focus of the memory box is on bringing the past to the present, enabling the child to work in the here and now, thereby aiding the grief process. The process of making and filling the memory box raises the level of awareness of the child's life and purpose, grounding her in the here and now. AIDS orphans in the middle childhood phase of development could be empowered, restoring a sense of belonging, enabling them to become self-actualising and self-supportive within the supportive group setting.

Due to a severe lack of funds and awareness, there is a lack of emotional assistance available to AIDS orphans in their middle childhood phase of development. They are precluded, by poverty or ignorance, from currently available forms of psychotherapy. The memory box medium will be used, in group therapy, to assess the effectiveness that recreating one's life story has on the self-concept of the child, orphaned through AIDS. Quantitative measures will be used to gather data, as it can be applied in a standardised manner. The researcher will also attempt to gain a holistic understanding of the problem through direct observation of the individual children during the group sessions. The unit of analysis will therefore be the individual child within a group setting.

## **1.3 Aim of Study**

The aim of this study is to explore and describe the utilisation of the memory box as a medium for telling one's story in Gestalt group play therapy, with AIDS orphans in the middle childhood phase of development. It is thought that through

making a memory box each child will have the opportunity, through recreating and telling her story, to reconnect with her roots. This self awareness and being part of a supportive group may lead to an increase in the child's self-concept.

The hypothesis is thus: The making of memory boxes in Gestalt group play therapy sessions will empower the AIDS orphans, aged 7-10 years old, increasing their self-concepts, resulting in a restored sense of self.

#### 1.3.1 Objectives of this study

- To explore and describe Gestalt play therapy with AIDS orphans in middle childhood.
- To capture the respondent's baseline data with the use of a self-concept scale as measurement for change, after Gestalt therapeutic intervention.
- To identify the respondent's responses towards the utilisation of the memory box.
- To capture post-treatment functioning in order to ascertain whether the memory box, as a medium for telling one's story, in Gestalt group play therapy with AIDS orphans has had any positive results.

### 1.4 Paradigmatic Perspective

The paradigmatic perspective of this study will be based on the Existential, Humanistic paradigm, focusing on the Whole Person Theory and Holism as outlined by Perls, Hefferline and Goodman (1951). This advocates that the individual has freedom of will and of choice, and it is this ability to make choices about life and oneself that makes the individual who they are. One must, however, take into account the constraints that influence an individual's decisions, for example the environment in which the individual finds themselves, influences the way in which they develop their sense of self. This self-concept influences the beliefs that the individual holds about their potential, but it also allows for the possibility of change. We choose to be whom and what we are. Life, then, is not about the struggle to survive but the struggle to find meaning in life. The individual, then, is

driven by the will to find meaning in life, to find out what is valuable and therefore meaningful to them. Each individual has the responsibility to make sense of, and to contribute to, their life, striving for self-actualisation, given their own limitations and those of their environment. The individual must be aware of these, but this is not to say that they cannot be overcome, as the individual has an active role in the subjective experience of their world. From a therapeutic perspective, the starting point must be to create an environment where the individual can see and accept herself exactly as she is. This is conducive to Gestalt play therapy.

The meta-theoretical assumptions will be conducted from a Gestalt play therapy paradigm and discussed in a later chapter. This ensures that the issues dealt with during the group play therapy sessions are dictated by the child, and that the starting point for each session is where each individual child is at the moment of intervention. The researcher's position and relationship to the children is one of facilitator, whereby each child is given the responsibility of bringing to each session her own story in the form of feelings and contributions in whatever form possible.

## **1.5 Ethical Measures**

Paramount to this research is ensuring the well being of the child which must be kept in mind at all times. It was ensured that the processes of conducting this research in no way put the child at risk. A facilitator and a co-facilitator were present in the group sessions at all time in order to ensure that private issues that may affect a particular child were resolved immediately and in private. The researcher ensured that all participation in the group sessions were voluntary with informed consent from the child and her guardians. The subjects will remain anonymous. Debriefing was conducted in the form of an individual session with each child after the completion of the group sessions (Strydom, 2004: 73).

## **1.6 Proof of Validity and Reliability**

A standardised test, The Piers-Harris children's self-concept scale, was used. Since this is a standardised test, the validity and reliability of the measurement has already been established. This test gives a measure of the total self-concept and six domain scales, these are behavioural adjustment, intellectual and school status, physical appearance and attributes, freedom from anxiety, popularity and happiness and satisfaction. The test was administered before and after the intervention, to establish whether any change took place in the individual child's self-concept including the child's assessment on her behavioural adjustment, intellectual and school status, physical appearance and attributes, freedom from anxiety, popularity and happiness and satisfaction (Piers & Hertzberg, 2005: 20).

## **1.7 Conceptual Framework based on Existing Literature**

With the death of a parent or the loss of a caregiver, and therefore the loss of their support structure, AIDS orphans experience many traumas, which may lead to a loss of their self-concept. Through the Gestalt group play therapy process and the reconstruction of their lives through making memory boxes, their sense of self is restored, reconnecting the child with her past, thus empowering her to deal with her losses in the here and now. By increasing her awareness, and offering her a tangible reminder of her roots in the form of the memory box, she has something to hold on to at times when she may feel scattered. Gestalt group play therapy will be used, as this ensures that the starting point for each child is where the child is at that moment. The process will therefore be different for each child within the group. The developmental tasks of a child orphaned during the middle childhood stage of development may be significantly affected, especially given the stigma attached to AIDS.

## **1.8 Research Methodology: Design and Method**

The research was quantitative in nature and the research findings therefore objective, as a standardised measuring instrument and procedure was used. There was a less dominant aspect of qualitative research included as the experience of the AIDS orphan, during the process of Gestalt group play therapy using the memory box as a medium, were described. The type of research undertaken was Applied Research as the aim was to explore and describe the Gestalt play therapy process using memory boxes as a medium. It is at the same time evaluative, since the researcher aims to assess the applicability of this play therapy medium in a group setting with AIDS orphans.

The research method used was the Single-Systems Design, where each child was matched with herself. A baseline measurement served as a control for comparison, with data collected during and after the completion of the group therapy sessions. In addition to the planned observation and comparison of pre-intervention (baseline) and post-intervention of self-concept, including the six domains, ongoing observations of each child took place throughout the group sessions.

## **1.9 Data Collection and Analysis**

### **1.9.1 The research population**

The universe refers to all potential subjects who possess the attributes in which the researcher is interested and from which a sample could be drawn. The universe for this research, therefore, would be all AIDS orphans in the middle childhood phase of development.

The population sets boundaries on the universe, and consists of a select group, which has the possibility of being the focus of the research. In this study the population was all AIDS orphans in the middle childhood phase of development, living in Johannesburg, attending Johannesburg Girls Preparatory School in Berea, Johannesburg inner city.

### 1.9.2 Sampling

If one wants to collect accurate information about a group of people, the best strategy is to examine every single member in that group. It is, however, also possible to reach accurate conclusions by examining only a portion of the group. In this study the sample was five primary school children, between the ages of 7 and 10, from Johannesburg Girls Preparatory School in Berea, who have been identified as AIDS orphans by members of the staff at the primary school.

### 1.9.3 Sampling method

Sampling techniques are divided into probability and non-probability methods. Probability sampling refers to samples where each unit has an equal chance of being selected. Non-probability sampling refers to samples where the units do not have equal chance of being selected.

The researcher selected the children according to a non-probability sampling technique, namely purposive sampling. This method is based on the judgement of the researcher regarding the characteristics of a representative sample, and the sample is chosen on the basis of what the researcher considers to be typical. In this case, children were chosen according to the following characteristics:

- AIDS orphans
- Girls between 7 – 10 years old
- Ability to work in English
- Not previously being referred to play therapy

### 1.9.4 Methodology

- Each child completed a pre-test at the first group play therapy session. The pre-test used was the Piers-Harris Children's Self-concept Scale.
- The children took part in a play therapy group session at weekly intervals.
- The memory box technique was used in these sessions.
- After completion of the memory box, the child completed the post-test where the Piers-Harris children's self-concept scale was repeated.



- Results on the pre-test and post-test were compared to establish whether the play therapy sessions, using the memory box as the medium, has resulted in change in the individual child's self-concept.

### **1.10 Research Layout**

The research report is divided into the following sections:

Chapter 1	Introduction: A brief overview of the research
Chapter 2	Theoretical Assumptions: The middle childhood phase of development
Chapter 3	Meta-Theoretical Assumptions: Gestalt play therapy considerations with AIDS orphans
Chapter 4	Method of Inquiry and Intervention
Chapter 5	Conclusion and Recommendations

### **1.11 Definition of Key Concepts**

#### **1.11.1 Memory box**

The memory box is a therapeutic technique, facilitating the retrieval of memory and encouraging the child's own narrative. The process of decorating the memory box fosters relationship building and the filling of the box creates a personal legacy for the child.

#### **1.11.2 Gestalt play therapy**

Gestalt play therapy is a psychotherapeutic process, which focuses therapy on what is immediately present. It is assumed that children will play out their problems expressing their emotions in a verbal or non-verbal manner. Children are encouraged, through play, to channel their emotions more effectively by becoming aware of their experiences in the here and now.

#### 1.11.3 AIDS orphans

For the purpose of this research AIDS orphans will be defined as children under the age of fifteen years old, who have lost one or both parents through AIDS.

#### 1.11.4 Middle childhood development phase

The middle childhood phase of development refers to developmental stages that occur in children between the age of six and twelve years of age. They include physical, intellectual, social, moral and emotional challenges, which encourage change and growth.

### 1.12 Limitations of the Study

- The sample used in this study was drawn from Johannesburg Girl's Preparatory School and as such, findings can only be generalized to that population.
- The sample consisted of only female respondents, therefore the findings cannot be generalized to include males.
- The sample included females between the ages of seven and nine years of age. The findings cannot be generalized to include all children in the middle childhood development phase, being children between the ages of six and twelve years old.
- No control group.

### 1.13 Conclusion

A standardised test, The Piers-Harris Children's Self-Concept Scale, was carefully selected as the research instrument in order to resolve the stated problem. This standardised test assured validity and reliability of the measurement. The method selected to administer the self-concept scale was the Single-System Design, where five AIDS orphans were selected in order to reach the goal.

All ethical measures, the key concepts and the layout of this report were discussed in this chapter. In chapter two, the theoretical perspectives, explored as part of the literature review, will be given in order to provide an in-depth background on the phenomena.

# **CHAPTER TWO**

## **THEORETICAL ASSUMPTIONS THE MIDDLE CHILDHOOD DEVELOPMENT PHASE**

### **2.1 Introduction**

Development can be seen as the sequence of age-related changes that occur in a person as they progress from conception to death. It can be described as a reasonably orderly and cumulative process that encompasses both biological and behavioural changes that take place as people mature (Weiten, 2001: 432).

In the developmental process, play forms an important part of childhood. Its importance lies in enabling the AIDS orphan to link the real world with her inner world. Through play the AIDS orphan is able to transform and make sense of her world according to her desires. McMahon (1992: 2) states that making sense of the world is an enormous task for the young child and she may often be at risk of being overwhelmed by events or feelings. Solitary play can be seen as an indispensable harbour for the child, allowing her space to overhaul her shattered emotions, after periods of rough going in the social seas (McMahon, 1992: 2).

McMahon (1992: 3) found that the development of the child play follows a predictable pattern. It is linked to aspects of physical, intellectual, social and emotional development. It is therefore important that the play therapist recognises and takes cognisance of the child's level of development. This enables the therapist to work with the AIDS orphan at the appropriate developmental stage, thus facilitating the child, to work through her problems effectively.

Although changes in play may be observed, repetition, endless variation or elaboration of a certain role is common. The child explores the issues she faces and learns new patterns which will replace the earlier dysfunctional ones whilst retaining a golden thread, which runs from birth to death. Sometimes the developing child

herself is reaching or striving for new relationships, while at other times the world or environment is beckoning to aspects of the child that are ready to emerge. The AIDS orphan, however, is often thrown in to the world without testing and experimenting with relationships, as she grapples to make sense of her losses.

Thomas (2001:1) describes human development as the way people mature with the passing of time. The child growing taller and mentally more adept would probably be considered developing, however the elderly person shrinking in stature and having difficulty with remembering names cannot be seen as developing, thus development is more than the mere passage of time.

## **2.2 A Theoretical Overview of Development of the AIDS Orphan**

Creating a human development theory is never a finished venture. According to Thomas (2001: 25), the process of theory construction always leads to inadequately answered questions, which in turn suggest issues yet to be resolved. Various theories will be introduced to indicate the developmental influences on the AIDS orphan. The emphasis will be on the Nature/Nurture Debate, looking at the Theory of Behaviourism, Psychoanalysis, Maslow's Hierarchy of Needs Theory and Erikson's Critical Period Theory. Normative and non-normative influences of development, evident in Psychodynamic Theory and Gestalt Theory, will also be considered. Constructivism in human development will be discussed with regard to Piaget's Cognitive Development Theory. Throughout the theoretical inquiry of the middle childhood phase of development, a link between the AIDS orphan and each developmental task will be explored.

### **2.2.1 Nature versus nurture**

The debate of nature versus nurture is a heated one. Louw, in (Hook, Watts & Cockcroft, 2002: 18), said that to accept the complexity of nature/nurture interactions one must also accept that this effect will be different for each individual. The developmental effects will therefore differ from person to person and hence from AIDS orphan to AIDS orphan. Thus, no fixed formula exists for

predicting the effect of heredity or environment upon a specific person. In addition, it cannot be assumed that both factors play an equal role in all stages of development.

Judith Harris, (in Santrock, 2003: 141), argues that what parents do does not make a difference in their children's behaviour. She argues that children's genes and their peers are far more important than their parents in children's development. However, research by Azat, 2002 and Cicchetti & Toth, 1998 (in Santrock. 2003: 141), indicate that children who grow up being abused by their parents often have problems regulating their emotions, becoming securely attached to others, developing competent peer relations, and adapting to school. These individuals more frequently develop anxiety and depression disorders. This seems to contradict the claim made by Harris that parent's behaviour does not influence children's development. The developmental process of the AIDS orphan, often exposed to the trauma of her parent's illness and death, may be affected. This may be due to the loss of the nurturing influences of her parent.

#### 2.2.1.1 Behaviourism

Behaviourism can be simplified to seeing human development as dependent on two aspects:

- a) The variety of behaviour options or potential ways of acting that the child acquires, and
- b) The child's preferences among those options. As the child interacts with the environment, she learns to prefer rewarding over non-rewarding actions, thus these may become her preferred option (Thomas, 2001: 14).

Development in the middle childhood years would continue as it has in the younger years, with the AIDS orphan having to create greater behavioural options in order to survive her extraordinary circumstances.

#### 2.2.1.2 Psychoanalysis

Dynamism, that is the process of changing dynamics, is the central assumption of Freud's Theory and is based on two drive instincts:

- a) The life instinct which energizes people's creative, developmental oriented, proactive, affection-seeking acts; and
- b) The death instinct which is a destructive counter force that competes against the life instinct in directing human behaviour.

According to Thomas (2001: 9), this Theory proposes that humans are dynamic organisms constantly compelled to satisfy their needs by reacting with their environment. Freud proposed that the child would progress through a series of psychosexual stages from the time of birth to mid-adolescents. From this perspective the level of developmental discord depends on how well she fulfilled her urges and advances through the psychosexual stages (Thomas, 2001: 11). The development of the AIDS orphan may not be compromised due to natural progression through the stages, irrespective of environmental factors. Freud's Classical Theory emphasizes the psychosexual development of human beings, especially the child's development and gratification of her needs.

Freud suggests that there are eight phases in the life of a person. The AIDS orphan in the middle childhood phase would be in stage four, the latency phase. Freud saw the child's development task in the latency period, between ages 5 and adolescents, as making her way in the world outside the family, especially in the domain of school and the peer group (McMahon, 1992: 20).

#### 2.2.1.3 Hierarchy of Needs

Abraham Maslow (in Meyer, Moore & Viljoen, 2002: 337) expands on the understanding of the needs of human beings in the developmental process. He identified a hierarchy of needs for both adults and children. He suggested that if lower level needs are not met, the individual could not direct their energies towards fulfilling higher level needs.

The levels he indicated are:

- Physiological needs as the lowest level.
- Need for food, water, rest, air and warmth.
- Need for safety.
- Need for love and belonging.
- Need for achievement of self-esteem.
- Need for self-actualisation as the highest level.
- The achievement of personal goals at highest levels.

According to Geldard and Geldard (2002: 31), Maslow's Theory is important because the therapist must establish the level of need fulfilment that the AIDS orphan has attained in order to assist in the developmental process and the resolution of crises. The AIDS orphan may find herself in a position where her basic needs are not met; this may have severe implications for her development as she will not be able to progress further without first finding a way to fulfil the basic need of food and shelter.

#### 2.2.1.4 Development Theory based on "Critical Periods"

This theory is based on the thinking that human development is time sensitive. The most popular theory is Erikson's Epigenetic Theory. Erikson viewed development as an auto-therapeutic process, where the successful resolution of a developmental crisis repairs the wound of the conflict involved and gives the individual a sense of achievement. Thus, it is postulated that there is a specific time during development when a given event has its greatest impact. Lenneber, (in Hook, Watts & Cockcoft, 2002) proposed that the critical period for language development is before puberty. Erikson (in Meyer et al, 2002: 194), believes that the critical period for development of emotional and social responsiveness in humans is before the age of three. Perhaps more importantly is the concept of readiness, the point at which an individual can be said to have matured sufficiently to be capable of a particular behaviour.

Erikson's Eight Staged Development Theory states that a stage is a developmental period during which characteristic patterns of behaviour are exhibited and certain capacities become established. According to Weiten, (2001: 445) stage theories assume that:

- Individual's must progress through specified stages in a particular order because each stage builds on the previous stage,
- Progress through these stages is strongly related to age, and development is marked by major discontinuities that usher in dramatic transition in behaviour.

Erickson (in Meyer et al, 2002: 198) divided the life span into eight stages. Each stage has a psychosocial crisis involving transition in important social relationships. According to Erickson (in Weiten, 2001: 445), personality is shaped by how individuals deal with these psychosocial crises. Each crisis involves a struggle between two opposing tendencies.

Erikson's Theory of Human Development assumes that everything has a ground plan, a predetermined schedule, in terms of which each part of a developing organism will have a special time of ascendancy. The time of ascendancy is a critical period, in which maturational growth must take place, failing which, detrimental effects will result. Hook, Watts & Cockcoft (2002), state that it is important to note that growth occurs in a regular and sequential fashion, moving in an orderly and cumulative manner, from one developmental stage to the next, until each part of the individual has developed. Each stage on the maturational timetable can be tied to a key social life-challenge or crisis and thus to a crucial point of physiological development. Each stage also marks a turning point where the individual either turns towards greater personal competence or greater weakness and vulnerability. According to Geldard and Geldard (2002: 32) and Santrock (2003 134), Erikson trusted that individuals had the potential to solve their own conflicts. The AIDS orphan in the middle childhood phase may be overwhelmed by the death of their parent and this may lead to greater vulnerability and an inability to solve these conflicts adequately.



### 2.2.2 Normative and non-normative influences in human development

Normative events are seen as those that occur in a similar way for most people in a given group. Non-normative life events are unusual events that have a major influence on an individual's life. Typical, normative events are events that take place at an expected time, for example the death of a parent in old age. Atypical, non-normative events take place unexpectedly, for example the sudden death of a parent or child (Hook et al, 2002: 23).

#### 2.2.2.1 Psychodynamic Theory

Jung saw self as the centre and the totality, the source and the goal of human life. He saw the self as mysterious and divine. Humans, therefore, have the unique capacity for self-realisation and the movement towards the spiritual realm, which is not seen in other species.

According to Hook et al (2002: 132), the self is seen as a synthesizer and mediator of the opposites within the psyche. The individual is concerned with the establishment of her unique identity and with fitting this with societal norms and ambitions. "The individual must break the tie to an archetypal mother. The hero archetype must slay the 'dragon' that keeps the hero afraid, and embark upon a journey of self-discovery. The father archetype, as the spiritual principle, counteracts the regressive longing for the Great Mother and unconsciousness. The father opens up the world beyond the mother" (Hook et al, 2002: 135). The task therefore of the AIDS orphan in the latter part of the middle childhood developmental phase would be to process and incorporate both normative and non-normative events into her self. The AIDS orphan is challenged by the premature death of their parent and must assimilate this with the developmental tasks of exploring the greater world without the security that a parent may engender.

#### 2.2.2.2 Gestalt Theory

Gestalt or Holistic Theory views the development of the AIDS orphan as developing as a unitary, integrated organism. Development is seen as proceeding

by small, additive increments that gradually accumulate to form the personality and this determines the child's repertoire of acts. However, according to Thomas (2001: 15), a new stimulus or experience, normative or non-normative, does not simply add a new element to a child's store of knowledge, leaving the previous elements undisturbed. Rather each new experience alters the relationship of many or all of the existing elements that have made up the personality of the child at the present time. Therefore the patterning of the entire personality is influenced by each and every experience that the AIDS orphan has. Lewin (in Thomas, 2001: 15), calls this the child's life space. A person's life space consists of all facts that influence the individual's behaviour at a given time. Life space, therefore, includes forces which the person is unaware of as well as things the person accepts as real, some may be verifiable and others mere fantasies.

Lewin (in Thomas, 2001: 15), summarized development into five growth principles defining a child's life space:

- The growing child's life space becomes increasingly differentiated. Words can be used in different contexts.
- Boundaries between regions become increasingly rigid. Words have separate meanings, the child is able to borrow and lend.
- During the process of development, life space expands in terms of time, space, and number of regions or components.
- The regions within a child's life space become increasingly organised and interdependent. Organizational interdependence consists of different regions becoming arranged in hierarchical systems or sequences of action, designed to achieve more complex or distant goals. The older child can plan steps necessary to achieve a visualised end product.
- Development increases realism. Achieving a more realistic concept of life involves distinguishing between (a) what might be, or the way we wish or imagined things were and (b) the way things really were.

The death of a parent is in itself a traumatic life experience having vast ramifications. When this crisis leaves the child an orphan, possibly alone with no

support system, the normal developmental process may be disrupted and the effects felt throughout the developmental process.

### 2.2.3 Constructivism

Constructivism refers to mental development that traces the stages through which a child constructs the components of her mind (Thomas, 2001: 16).

Cognitive development therefore refers to the transition in the AIDS orphans' patterns of thinking, which will include an increased ability to reason, remember, and improved problem solving skills. This development depends on the maturation of the child's intellectual capacity, shaped by environmental challenges to which an AIDS orphan must adapt. The AIDS orphan is confronted with several extreme environmental challenges, which may influence this development of cognition.

The most important research on cognitive development was conducted by Piaget (Santrock, 2003: 128). Piaget analysed children's adaptation through their interaction with human and non-human objects in time and space. These operations were conceptualised as the developmentally appropriate cognitive methods, employed by the child to organise schemes and experiences and to direct actions.

#### 2.2.3.1 Piaget's Theory

Piaget was more interested in how children used their intelligence rather than simply measuring their intelligence. According to Weiten (2001: 448), the most important contribution by Piaget was his development of a stage theory of development with four major stages. Development was seen by Piaget as the process, where, as the child becomes more adaptive, she develops higher levels of cognition and starts to understand her environment in an increasingly complex way (Geldard & Geldard, 2002: 32). In Piaget's theory, the purpose of all thought and overt behaviour is to enable the child to survive and flourish by adapting to her environment in ever more satisfactory ways.

According to Piaget (in Santrock, 2003: 128), development consists of the child constructing an expanding collection of schemes through transactions with the changing environments. Thomas (2001: 18) noted that to account for why younger children construct fewer and simpler schemes than do older children and adolescents, Piaget proposed four causal factors affecting the development process:

- a) Heredity; sets the pace of the internal maturation of the child's neuromuscular system. The particular level of maturation that children reach at a given time determines how well they can profit from various engagements with their environments. The child must be maturationally ready in order to perform particular assimilations and accommodations. While the heredity factors of the AIDS orphan are determined at conception, and are unchanged by the death of their parents, other factors such as having contracted HIV at birth may compromise their ability to realise their potential.
- b) Physical experiences; within the world of objects and people the child is required to actualise the potential that internal maturation provides at successive stages of development. An AIDS orphan isolated from the world, thus denied experience, may not develop adequately.
- c) Social transmissions; in the form of instruction from parents and peers, can further expand the child's schemes. The AIDS orphan will be denied the ongoing opportunity to learn from their parents.
- d) Equilibrium; entails the process of keeping the foregoing factors in balance. Due to the stress and lack of support, the AIDS orphan may struggle to balance her development and may become increasingly disadvantaged.

The developmental path of the AIDS orphan is similar to any other child. Each child is an individual, and therefore each AIDS orphan is also an individual and develops in a unique manner. However, given the trauma of becoming an AIDS orphan, many developmental tasks could be compromised. It is important to be able to meet the AIDS orphan where she is developmentally, to be able to understand and foster her development.

## **2.3 Developmental Tasks in Middle Childhood**

Each child builds up her own private frame of reference, which is more or less consistent with the public world of her significant others. However these references are warped, distorted and always infused with the emotional reactions of the child. In other words, we may see the AIDS orphan as learning to live overtly according to our adult consensual world-view, but inwardly maintaining her own private world of meanings and values. The AIDS orphan's world is full of feelings and emotions that she increasingly feels the need to guard from others, especially when one takes into account the stigma often attached to AIDS related deaths. Every AIDS orphan learns that every lesson is coloured with an emotional element, irrespective of the actual experience. Thus, as Frank (in Landreth, 1982: 19), said, developmentally, the child matures by continually altering her awareness of her world. This continuous never ending process of relating herself transactionally to the world, embraces all the basic physiological functions and sensory processes.

The AIDS orphan has to adapt to her world and all its experiences, without her parent being a part of it. The AIDS orphan's awareness, perception, cognition, motor activity, emotional reactions and affective responses, interpersonal and group relations and social conduct are all involved in their development, all of which may be dramatically altered by the death of their parent. According to Frank (in Landreth, 1982: 21), by viewing the organism personality as engaged in these varied and ever-changing relations, we can begin to define our conception of human development.

We can observe this process in a field and see the AIDS orphan at play, engaged in dynamic, circular, reciprocal relationships where she learns to face the harsh reality of her everyday life. The child, while at play, relates herself to her accumulating past, by continually reorienting herself to the present through her play. She rehashes her past experiences, assimilating them into a new perspective of patterns of relating to herself, thereby advancing into the future. She freely reorganises her past into her future (Blom, 2004: 58).

### 2.3.1 Physical development

The period of middle childhood involves slow, consistent growth. It is the period of calm before the rapid growth spurt associated with adolescence (Santrock, 1992: 300). The child's legs become longer, her trunk slimmer and her muscle tone improved. The child doubles her strength capabilities during this time. Middle childhood is also a time where motor development becomes smoother and most children can learn to play sport. According to Santrock (1992: 300), these physical developments are often a source of great pride and enjoyment for the child and her parents. Increased development and growth takes place helping the nerve impulses to travel faster, this is reflected in the improvement of fine motor skills during middle childhood. This physical growth and change can however be a source of anxiety for the AIDS orphan who may not have a caring adult to explain and share these changes with her.

### 2.3.2 Intellectual development

Intellectual development refers to how the child acquires, interprets and stores information about her world. It also reflects how the child uses this information and knowledge to direct her behaviour.

Piaget (in Santrock, 2003: 130), saw the ages of 5 to 7, the middle childhood phase, as marking the age when the child moves from pre-operational to concrete operational thought. Piaget defined an operation as a reversible mental action. In the pre-operational period, the child is unable to perform reversible mental actions, while in the concrete operational period she can perform reversible mental actions on real, concrete objects, but not on abstract objects. The child's thinking now becomes less intuitive and egocentric and more logical.

The child, in the concrete operational stage, gradually masters the concept of conservation in a series of stages. At around 7 or 8 years old conservation of number and weight are developed, last to develop is conservation of area around the age of 11. The concrete operational child is able to mentally compare different objects and find similarities and differences between them. She is also able to theorise about the world and even speculate about things and try out her own

theories. The impact that this has for the AIDS orphan is that she is now able to form hypotheses as to the nature of her parent's illness. The AIDS orphan is also better able to understand her role in the events that led to the death of her parents. Hook et al (2002: 186) stated that Piaget maintains that skills and operational ability develop gradually and sequentially as basic skills are acquired and consolidated, reorganizing them into increasingly more complex mental structures.

The concrete operational period usually lasts from 7 to 11 years. He called it concrete operational because the child can perform operations only on images of tangible objects and actual events. Reversibility permits a child to mentally undo an action while decentration allows the child to focus on more than one feature of a problem simultaneously are examples of this (Weiten, 2001: 449). The ability to decentre, to consider various aspects of a matter, is found in the child at age nine, Ramkison (in Louw, van Ede and Louw, 1998 328). This will enable the AIDS orphan to understand that she had no part in the reasons for her parent's death, and she may also be able to consider the various options available to her with regards to her future.

Concrete operational thought involves using operations and replacing intuitive reasoning with logical reasoning in a concrete situation. Santrock, (2002: 131) stated that classification skills are present, but abstract thinking is not yet developed in this stage. This new ability to coordinate several aspects of a problem helps the AIDS orphan appreciate that there are several ways to look at things which may lead to a start in decreased egocentrism.

In so far as the world is familiar and what they are doing makes sense to them, the child in the middle childhood years will use concrete operational thought to understand cause and effect through their observations of the world. This child is rarely capable of abstract thinking, making it difficult for the AIDS orphan to understand the effect of her situation on her life or to understand the implications of trauma on her development. Intuitive thinking still persist where cause and effect cannot be clearly understood, and the AIDS orphan's egocentricity will mean that she will often perceive herself as the cause of events. She may even blame herself for the death of her parent. van Dyk (2005: 150), is however of the opinion

that this child can be reassured by providing simple concrete explanations of the reasons for events. After 8 years of age the child may start to become aware of the complexities of relationships and may need more rounded explanations. The AIDS orphan begins to understand that relationships are conditional rather than absolute.

The child in the middle childhood phase of development begins to consider the possible feelings and emotions that other people may have, and that if situations and feelings can change, they can also be reversed. The AIDS orphan, who has suffered loss, needs to enter the process of “adaptive grieving”, this may involve a period of disturbed behaviour at home or school, as she goes through the stages of shock and denial, protest and despair, in order to reach a new integration. According to McMahon (1992: 20), the child in this phase understands death, but this understanding remains related to concrete events and situations.

### 2.3.3 Emotional development

Middle childhood is the time of greater emotional maturity. This marks the beginning of a move from helplessness to independence and self-sufficiency. It also allows for greater emotional flexibility and greater emotional differentiation. Emotions during middle childhood are more specific, more diverse and more sophisticated. According to Louw et al (1998: 345), greater emotional differentiation also enables the child to express a variety of emotions and thus express herself with more accuracy.

Gender-role stereotyping does, however, influence the nature and quality of emotional expression, and although the child needs to express her emotions, stereotyping often prevents such expression. For example, boys are often taught not to cry and to show no fear, while girls are often criticized if they show aggressive tendencies. Such gender-role stereotyping prevents the child from using her full repertoire of emotions, thus resulting in truncation of her emotions (Louw et al, 1998: 345).

Van der Zanden (in Louw et al 1998: 345), points out that the child’s understanding of her emotions and emotional experiences change noticeably during middle childhood,



that is, between the ages of six and eleven as they increasingly attribute emotions to internal causes:

- She becomes aware of the social rules governing the expression of her emotions;
- She learns to “read” facial expressions with greater accuracy;
- She begins to understand that emotional states can be changed psychologically (e.g. By thinking of something pleasant when you feel unhappy); and
- She realises that people can experience different emotions simultaneously.

The child in the middle childhood development phase is capable of identifying emotional labels such as anger, fear and happiness, and attributing inner feelings to them. They are better able to control their emotions and are now able to hide their feelings (Louw et al, 1998: 346). The AIDS orphan is therefore able to identify her feelings and may choose to talk about them. However, she is also able to hide her emotions, which could lead her caregivers to assume that she is coping well with the death of her parent when in fact she is struggling.

Middle childhood is a time where the child reports that she has many fears. The fear that parents could die is common in this period. Children’s fears keep up with the times in which they live, today’s children are also afraid of pollution, nuclear war and violence (Louw et al, 1998: 348, van Dyk, 2005: 151).

The importance of attachment and the attachment theory at this stage is a priority in forming and maintaining relationships. Attachment was analysed in terms of its survival factor. Belsky (in Weiten, 2001: 444) states that the nature of a child’s early attachment experiences depend on the character of the environment in which she finds herself, and that these experiences chart the course of the child’s social developmental circumstances.

Lack of emotional development is undoubtedly the greatest risk to which most AIDS orphans are exposed.

#### 2.3.4 Social development

Middle childhood is the stage of development where the child has gained a rudimentary sense of autonomy. The child is now able to enlarge her experiential field. This is the stage in which the social environment of the child challenges them to be active and directed in mastering specific tasks. The child is asked to assume an increasing amount of responsibility for herself, for her body, and even, occasionally, for siblings (Hook, et al, 2002). This benefits the AIDS orphan as she now finds herself having to take care of herself, not by choice, but out of necessity.

Erikson developed the psychosocial stages of development out of Freud's Psychosexual Theory during the 1930's. The fundamental difference between the theories rests on the question of what drives human behaviour. Erikson (in Santrock, 2003: 134) found that at certain ages throughout life, a particular development task or crisis would arise, which would indicate a turning point towards greater personal competency or vulnerability.

The child in the middle childhood phase of development would fall into Erikson's age of industry, in which the child learns the skills of their culture. If she is made to feel inadequate compared with other children, she may develop a feeling of inferiority, which in turn may affect the development of her skills. Social play with peers also contributes to these feelings. The degree of success in schoolwork and experience in the home and neighbourhood also contribute to the outcome of this crisis. Adults other than parents are greatly admired, and their opinion of the child may affect the development of self-esteem (McMahon, 1992: 20). The AIDS orphan in South Africa often has to drop out of school due to the stigma that is still associated with AIDS. This may have devastating effects for the child, as according to Erikson's Epigenetic Principle, this is the time in her life when she learns to master knowledge and intellectual skills. The outcome of this crisis thus results in a feeling of competence or a feeling of inferiority.

Erikson's stage of industry lasts roughly from six years old until puberty. The challenge of learning to function socially extends beyond the family, to the broader social realm of the neighbourhood and school. The child, who is able to function

effectively in this less nurturant social sphere, where productivity is highly valued, learns to value achievement and to take pride in her accomplishments, resulting in a sense of competence (Weiten, 2001: 447). The AIDS orphan, who is often exploited by the caregivers, feels a sense of inferiority.

Erikson's theory takes into account both continuity and transition in personality development. It accounts for transition by showing how new challenges in social relations can stimulate personality development throughout life. Continuity is experienced by drawing the connections between early childhood experiences and aspects of the adult personality influenced by these experiences (Weiten, 2001: 447).

Erikson's industry stage which corresponds with Freud's latency stage is a relatively calm period, where the child needs to consolidate the previous stages. This is a time when the child is able to fill in the gaps of those psychosocial skills, social roles, and levels of physical growth already achieved. At no other time are children more enthusiastic than during the middle childhood's period of expansive imagination. As the child moves into the primary school years, she directs her energy towards mastering knowledge and intellectual skills. The danger at this stage involves feeling incompetent and unproductive, thus feeling like a failure (Santrock, 2003: 135). In South Africa the AIDS orphan is either left to fend for herself or may be taken in by someone in the community. In most cases the development process is disrupted as the orphan is placed in a position where survival becomes the dominant task.

#### 2.3.5 Role of the family

The child, in the middle childhood development phase, spends much more time away from home than she did in her earlier years. The child, in a normal family setting, also spends far less time with her parents. Hill and Stafford (in Santrock, 1992: 341) found that parents spent less than half as much time with their children aged 5 to 12 in care giving, instruction, reading, playing and talking, than when the children were younger.

Nevertheless, the child's home is still the place that offers the most security and the family is still the pivot on which her life hinges, this is often denied to the AIDS orphan. Parents often have to protect the child and have to serve as a buffer between the child and the community. The family is also responsible for teaching the child moral, religious and cultural values. The family is the place where the child learns how she is expected to behave towards authority, how to handle interpersonal relationships and how to resolve conflicts. The child orphaned by AIDS is often unable to replace these vital structures, as prejudice and stigmatisation deters extended family from getting involved, thus leaving the child at risk.

#### 2.3.6 Peers

The child in the middle childhood years interacts with other children for the sake of friendship, affection and fellowship, whereas the child-adult interaction at this stage is more often based on the child's need for protection and care. The child does not choose her family, but she does, most of the time, choose her friends. According to Louw et al (1998: 366), the child in the middle childhood phase terminates a relationship with another child when she realises that she is no longer satisfied with the interaction.

A peer group in middle childhood is characterized by a relatively stable collection of two or more children who interact with one another. They share common norms and goals and have achieved a certain social structure of leaders and followers, which ensures that group goals will be met (Louw, 1998: 366). A peer group has certain goals and interests in common and the members of the group formulate their own rules and code of behaviour. Admission to the group is often controlled by the use of initiation rituals and passwords. Gangs flourish during this developmental stage. The peer group serves a vitally important task in middle childhood. It offers the following important developmental opportunities:

- Comradeship, especially where this is not available at home.
- Opportunities to try out new behaviours and learning social skills such as cooperation and negotiation.

- Transfer of knowledge and information. Sexual information often peppered with myths is discussed within the group at this stage.
- Obedience to rules and regulations form a very important part of belonging to a peer group.
- Development of gender roles, members are expected to conform to group norms.
- A weakening bond between child and parent occurs, this transfer of energy into the peer group and away from the family is an important development task leading to independence.
- Relationships compete with others on an equal footing. The peer group is a place where social skills are refined. Assertiveness, competitiveness as well as their cooperative and mutual understanding ability are explored.

For the child orphaned by AIDS, the peer group may become the only measure that she has to regulate her behaviour. The peer group often becomes her only form of support.

Excessive conformity and attachment to the peer group could however, also be detrimental. It could, for instance lead to children taking part in undesirable or illegal activities. This creates a great risk for the AIDS orphan as their need to belong may be at any cost. The excessive attachment to the group may be so strong that the child is prohibited from developing the necessary degree of self-reliance and independence, which should be achieved by the end of middle childhood (Louw, 1998: 368). This developmental pull towards peers makes group therapy an effective form of therapy for this age group (Lampert, 2003: 165).

Peers play an important role in gender development in middle childhood. Initially peer groups are highly segregated into boy groups and girl groups. Peers are stricter than most parents in rewarding what is considered gender-appropriate behaviour in the culture, and punishing gender-inappropriate behaviour. According to Santrock (2003: 147), towards the end of the middle childhood developmental phase, interaction between the gender groups begins.

In many ways the shift in focus to people outside of the family, evident in this stage of development, helps the AIDS orphan as she is able to make contact with others who may offer possible external sources of support.

#### 2.3.7 A wider sphere of social interactions

The child in this stage of development is developing an increasing number of skills and abilities, both at home and at school, and in the wider environmental field. She is preoccupied with the goal of gaining competence, proficiency, and mastering certain key tasks assigned to her, usually by parents and teachers. Energies once expended in play are now devoted to honing physical and perceptual skills required to achieve these goals. The child is now eager to apply herself to task-oriented activities.

The child's peer group comes to act as an extra-familial source of identification, and this group quickly becomes one of the most important influences on the developing personality of the child. The ability of the child to communicate and productively engage with her peers becomes highly valued, as does gaining the recognition and positive acknowledgement of her peer group. Children are almost constantly sizing one another up, measuring their own skills and worth in comparison to the norm. According to Hook et al (2002: 277), a great deal of emphasis is placed on considering who the best, the funniest, the strongest and the fastest is in the group. Social resources essential for the development of the child include material, social, and personal factors. Access to these social resources is reflected in the African proverb "it takes a village to raise a child" (Dalton, Elias & Wandersman, 2001: 222). Without social interaction and the social resources, often denied to the AIDS orphan due to the fear and stigmatisation, developmental tasks would certainly lag behind the average child.

#### 2.3.8 Self-image

During middle childhood the self-concept develops rapidly. According to Papalia and Olds (in Louw et al, 1998: 344), when a child is six or seven years old, she begins to define herself in psychological terms. She develops a concept of who she is, the real

self, and also of how she would like to be, the ideal self. The child now describes herself in terms of how well she can do something. Harter (in Louw et al, 1998: 344), found that by eleven years old the child's self-assessments correlate highly and significantly with the assessments of friends and teachers. The child's knowledge of herself is not only based on her achievements, but also on her needs, for example the need for friendship, and on what others expect of her (Louw et al, 1998: 345). The self-concept is also influenced both positively and negatively by the degree to which the child regulates her own behaviour. It is, therefore, important that the child should develop faith in her ability to meet her personal and social requirements out of the safety of her immediate family (Louw et al, 1998: 345).

Research by Coopersmith (in Louw et al, 1998: 345), revealed that the way in which the child was treated by adults, particularly her parents, played an important role in the development of her self-esteem. This has serious consequences for the AIDS orphan typically treated as an outcast, or growing up without the support and security of a parent. The child at this age continually evaluates herself in relation to group norms.

The danger is when the child feels inadequate and inferior relative to her social group. A negative evaluation of self is especially damaging at this time. The challenge is for the child to find a strong sense of identity apart from her nuclear family, within a receptive and affirming peer group. Should the child fail in this quest, and in the related quest to gain the necessary technical competencies relevant to her culture, then an abiding sense of inferiority and ineptness is often experienced. According to Hook et al (2002: 278) inferiority complexes, feelings of unworthiness, inability, and low self-esteem are rooted in this stage of development.

Success in education is a priority at this stage as the child's sense of self is enriched by the realistic developments of certain competencies. The child's sense of self begins to appreciate the pleasures of work-completion through steady attention and persevering diligence. The child is thus becoming a little adult. This experience is often denied to the AIDS orphan, especially if they are unable to continue to attend school, which is often the case in South Africa.

### 2.3.9 Moral development

Morality refers to a set of principles, which enable individuals to differentiate between right and wrong. According to van Dyk (2005: 151), it enables the child to judge behaviour in terms of it being either good or bad. Moral values and standards differ from one society to another. The ability to differentiate between right and wrong is another important developmental task to be mastered in middle childhood and requires competence regarding the following:

- Awareness and sensitivity to each social situation.
- Moral judgement as to what should be done in each particular situation.
- Values adhered to, to influence the individual's plan of action.
- Implementation of moral thinking into an action plan.

Piaget (in Mussen, Conger, Kagan and Huston, 1984: 324), stated that between 5 and 10 years of age children develop an enormous respect for rules. Rules must be obeyed at all times and no mitigating circumstances are taken into account. Louw, et al (1998: 375) states that the child has a simplistic belief in an immanent justice, and believe that punishment will follow a wrong doing, no matter how small.

Kohlberg (in Thomas, 1992: 501) proposed a theory of moral development. It consists of three levels with two stages in each. The child in the middle childhood years would most likely be in level one or two.

Level one: Preconventional Level where no internalisation of morality takes place.

- Stage 1: Heteronomous morality. At this developmental level of morality individuals pursue their own interests and let others do the same. What is right involves equal exchange, nothing else. The child is punishment and obedience orientation. Whether an action is good or bad depends on whether it results in punishment or reward. If the individual is going to get punished for it, it's bad so she shouldn't do it. If she won't get punished, she can do it, regardless of the human meaning or value of the act.



The AIDS orphan may, therefore, interpret the death of her parent as a punishment for some or other transgression. This could have enormous consequences for her healing and development.

- Stage 2: Individualism, purpose and exchanges. The child obeys simply because adults tell her to obey. People base their moral decisions on fear of punishment but also reward for good behaviour, metered out by the adults in their lives. This stage is seen as a naïve instrumental orientation stage. Proper action instrumentally satisfies the individual's needs and occasionally the needs of others. Human relations are based on getting a fair return for one's investment. Reciprocity or fairness involves "you scratch my back and I'll scratch yours." The AIDS orphan may wonder what she has done that was so "bad" that the adults in her life have left her alone. This is especially true as often no explanation is given for the parent's ill health.

Thus it can be seen that the preconventional level is based primarily on punishment or rewards and that these come from the external world (Santrock, 2002: 144). This is largely a premoral level, as the child follows society's rules of right and wrong, but only in terms of the physical or hedonistic consequences. The behaviour is based on punishment, reward or exchange of favours, and in view of the power that the authority that imposes these rules has. The child in this phase also believes in immanent justice, she may believe that sickness and death are a punishment for breaking the rules. This is a heavy burden for the AIDS orphan to bear, as she may believe that her behaviour is the reason for the death of her significant others.

## **2.4 Conclusion**

Development can be considered contextual as the child continually responds or reacts to the various contexts in which she finds herself. The AIDS orphan in the middle childhood phase of development is faced with challenges in every sphere of her development. The developmental tasks required of the AIDS orphan, and the constraints due to her orphan status, must be kept in mind when assessing the

AIDS orphan's progression. The developmental stage is vitally important when intervention is planned as it is imperative that the therapist meet the child where she is.

In Chapter 3 the process of Gestalt play therapy will be described with particular emphasis on Gestalt group therapy. Due to the importance of the peer group to the developmental tasks of the middle childhood phase, and the fact that this peer group, could, in fact, replace the family for the AIDS orphan, it is deemed to be the most suitable intervention strategy.

# **CHAPTER THREE**

## **META-THEORETICAL ASSUMPTIONS**

### **GESTALT PLAY THERAPY CONSIDERATIONS WITH AIDS ORPHANS**

#### **3.1 Introduction**

In Chapter two the development of the child was discussed. Therapeutic considerations with the child orphaned by AIDS will be introduced in this chapter. The process of play is to the child, what verbalization is to the adult. It is a comfortable medium through which the child expresses feelings, explores relationships, describes experiences, discloses wishes, and achieves self-fulfilment. The process of play may be viewed as the child's effort to gain control of her environment, and usually reflects her perception of the world.

According to Gestalt theory (Yontef, 1993), and (Oaklander, 1988), the problems that a child experiences do not exist in isolation, but as part of the whole milieu of which the child and the problem are a part. Therefore, play therapy needs to match the dynamic inner structure of the child with an equally dynamic approach (Landreth, 1982). According to Landreth (1991, 11), the play activity of the child, as her natural medium for self-expression, has stimulated much thought and experimentation into ways in which this play can be used in the treatment of the child in distress. The child orphaned by AIDS experiences related stresses and needs to be guided through a therapeutic process. In order to determine the therapeutic needs of the child orphaned by AIDS, a definition of the parameters of the AIDS orphaned child is needed.

Various definitions of AIDS orphans exist. The definition offered in 2002, by agencies such as UNAIDS (United Nations AIDS initiative), WHO (World Health Organization) and UNICEF (United Nations children's fund) will be adopted for the purposes of this study. These agencies defined AIDS orphans as children under the age of 15 years who had lost a parent to AIDS. In 2004 the definition changed

to include all children under the age of 18 that have lost a parent or both parents to AIDS (Ghosh and Kalipeni, 2004: 306), (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste and Pillay, 2005). AIDS orphans are children whose lives have been profoundly changed by the epidemic, and whose needs should also remain in our minds as we plan interventions (Richter, 2001: 30).

It is estimated that 13.3 percent of South African children between the ages of 2 and 14 years are AIDS orphans and 21 percent of children between the ages of 15 and 18 are AIDS orphans. The overall prevalence of orphanhood between ages 2 and 18 years is 14.4 percent (Shinana et al, 2005: 112). According to the Medical Research Council, at least 5.7 million children could lose one or both parents to AIDS by 2015 (IRIN news.org: 2005). HSRC (Human Science Research Council) estimates that 4.8 million people, approximately 10.8 percent of South Africans over the age of 2, are HIV positive (Africa Focus Bulletin, Feb 16, 2006). South Africa is the country that has the largest number of people living with HIV and AIDS in the world (Dorrington, Bradshaw and Budlender, 2002: 1). HIV and AIDS pose a serious threat to the psychological development of South African children. The impact for the millions who live with a parent or parents with AIDS is enormous, as it is for the huge number of children who have been, and stand to be, orphaned by the disease (Hook et al, 2002: 260).

The impact of HIV and AIDS has been dramatic, as unlike most infectious diseases, the most vulnerable are not the weak, very young or elderly. In South Africa the average age of those dying as a result of AIDS is 37 years (Pharoah, 2004: 2). The implications are therefore that they fall ill during the years that they are most likely to have children. This leaves the children at risk, not only of infection, but also due to illness or death infected parents are unable to care for them (Pharoah, 2004: 2), (Hook, 2002: 260). Schonteich (in Pharoah, 2004: 3), states that the growing levels of poverty and vulnerability together with the emotional trauma associated with AIDS related parental death and reduced levels of parental guidance has resulted in increased victimization of the child. This may increase the likelihood of delinquency and criminal behaviour, as their positive role models are too sick to exert any influence. Parental illness may also result in the parenting relationship becoming inverted. The child is increasingly expected to

take care of their seriously ill parents. The child is seen as a source of support and often has to assume the care-giving roles (Hook et al, 2002: 262).

Ways of dealing with these problems need to be found in theory and in practice. Besides the policy regarding social development in South Africa, clinical therapeutic intervention is needed in order to restore emotional distress.

In this study the Gestalt therapeutic method of dealing with emotional distress will be discussed, describing the Gestalt theory (philosophy) and Gestalt play therapeutic intervention focusing on the child orphaned by AIDS.

### **3.2 Gestalt Theory**

Gestalt theory is a radical ecological theory where there is no meaningful way to consider any living organism apart from its interactions with its environment. It brings self-realisation through here and now experiments in direct awareness, and can be considered as an existential, phenomenological and holistic approach. The prime principles therefore can be seen to include dialogue, phenomenological awareness and field theory (Yontef, 1993: 21). The emphasis of Gestalt theory is on awareness in the here and now, always taking into consideration the interdependence between people and their environment. Buber (in Yontef, 1993: 31) states that it is only through a particular person-to-person contact that healing can take place. This allows for organismic self-regulation, a powerful process brought about through experimentation. It is thought that only when people become aware of choices that they make in respect of their own behaviour, that real change becomes possible. This therefore, implies that humans can, and do, define the significance of their own lives.

In essence Enright (in Yontef, 1993: 55), states that the basic assumption of Gestalt therapeutic approach is that people can deal adequately with their own life problems if they know what they are, and if they can utilize all their abilities to solve them. According to Yontef (1993: 140), the emphasis is not therefore on what “should be” but on an awareness of “what is”. The person who is aware knows

what she does, how she does it, that she has alternatives and that she chooses to be as she is. A good Gestalt thus refers to a perceptual field, organised with clarity against the ground of a person's living context. This perceptual field is described within the Field theory.

### 3.2.1 Field theory

It is impossible to look at a person or her problems without taking into account the context in which she finds herself, also known as her environmental field. The interdependence between the person and her environment thus forms the central concept of the Gestalt approach (Blom, 2004: 4). This field is therefore defined by the observer and the client, and is only meaningful when one is able to understand their frame of reference (Yontef, 1993: 125). Aronstam (in Blom 2004: 9) states that although individuals function as independent entities, the healthy individual must also function as a holistic entity, where the environment is used effectively to satisfy her needs.

The suitability of Gestalt therapy for children can be found in the fact that awareness work through sensory contact-making is attractive to most young children – as discussed in the reasons children play. Children are generally inquiring creatures that explore their worlds through their senses. The dialogic component of Gestalt therapy, however, may not be suitable for children under the age of eight since the child's cognitive function does not support the deductive operations that are required.

A child-centred, Gestalt therapeutic approach has been conceptualized by Violet Oaklander (1978). Gestalt play therapy incorporates the Gestalt therapy philosophy with developmentally appropriate play therapy techniques. In developing the procedural guidelines for treatment, consideration of child-centred therapies was incorporated.

### **3.3 Gestalt Play Therapy with AIDS Orphans**

Gestalt therapy, as developed from the theoretical foundation of Gestalt, is focused on the here and now, but cognisance is taken of the fact that this may include residue from the past. During therapy the child is encouraged to be aware of her experiences in the here and now, but the effect that her past has on these experiences is also brought into the field. Thus, all the components of self, past and present, must be synthesised in order to survive, not as a fragmented entity but rather as a holistic, integrated entity able to choose and organise one's own field in a meaningful manner (Yontef, 1993: 126).

Blom (2004: 11) argues that the focus of Gestalt therapy must include the child's emotional, physical and spiritual aspects, including language, thought and behaviour, as this can never be seen in isolation from her subjective field. Through contact within the environmental field, a figure is formed. This could be an awareness of a physiological need or the emergence of an interest or preoccupation. According to Perls (1951:231) this figure is seen against the background of the environment and focuses on the process of awareness.

In Gestalt play therapy the quality of the therapeutic relationship and therapeutic dialogue is viewed as paramount, even more important than the techniques used. However Oaklander regards technique as imperative, she qualifies this by drawing attention to the fact that the child generally does not autonomously decide to seek therapy. Oaklander (in Kaduson & Schaefer, 2000: 29), states that the therapist must meet the child however she presents, without judgment and with respect and honour. The therapist holds no expectations, but maintains an attitude that supports the full, healthy potential of the child. As the therapist is involved, and creates a safe space for the child, it is assumed that the child will play her inner world, giving expression to significant emotional experiences by playing out her most pressing problems in this symbolic, non-threatening manner (Landreth, 1991: 9). Through play the child will become aware of her emotions and this awareness will enable the child to identify her own needs.

Through play she will be encouraged to identify the relationships in her life through which her needs may be met. By helping the child to accept what she has become without having to deny her unacceptable parts she is likely to experience clarity rather than confusion (Geldard & Geldard, 2002: 68).

Blom (2004: 11), states that in daily life children are exposed to a great variety of experiences that all influence their growth and development. Although children have a natural ability to recover from adverse experiences, the possibility exists that the lives of some children could be radically influenced, as is the case when children are left orphaned by AIDS. These children will be exposed, in varying degrees, to trauma and loss, stigmatisation and often poverty.

Children, according to Dane (in Webb, 2002: 265), who are orphaned by AIDS, not only face the challenges of loss and grief, but will be faced with additional vulnerability. Loss can be described as losing someone or something that has played an important role in the healthy functioning and existence of the child. Loss implies an element of separation, which leads to the child's experience of separation anxiety as she attempts to restore the equilibrium. The term grief refers to the emotional process and work that takes place following a loss. According to Blom (2004: 216) mourning refers to the process of adjustment and organic self-regulation which results from the loss.

Dane (in Webb, 2002: 266), states that children who live in families with AIDS undergo a particularly wounding experience as their loss includes the stigma, shame, secrecy, fear of disclosure, multiple losses and survivor's guilt associated with AIDS. When death of one's parents is accompanied by isolation and followed by instability and insecurity, the bereavement process is more difficult.

The child experiences the same series of emotions that adults do when they experience loss and grief, however, they often reacts in different ways. Frost in (MIET (SA): 18) rightly says that there is no right or wrong way to act in bereavement. The child, however, is often not capable of accurately verbalizing or expressing her emotions. It is thus important to help each child create awareness, as to how differently each individual reacts to their own loss (Landreth.1991: 15).



For a child affected by AIDS, the sense of loss and grief may begin long before the significant person becomes ill or dies. The child, according to Anderson (in Doka, 1995: 62), may be confronted with the possibility of her parent's death repeatedly, only to gain respite as the parent recovers, until the next crisis. These children may suffer loss, grief, depression, abuse, abandonment, isolation, loneliness, rejection and fear due to the stigma AIDS still has. This, in addition to physical discomfort, pain and hospitalisation they may encounter should they also be inflicted with HIV.

The fact that HIV and AIDS still carries a major element of stigma and secrecy, compounds the problem, and children are not able to utilize resources due to fears of rejection.

There is also the loss of the functioning adult, as this person may in effect be lost to the child although still alive. Often the child has assumed the added role of caregiver to the ill parent. The child's ambivalence about the parent's death may further complicate their response to the loss of the parent.

### 3.3.1 Awareness as part of the therapeutic process

Each person constructs her own world in a unique manner and her awareness of this world is also unique. Oaklander (1988: 53) describes the atmosphere in which children become aware, and the process of self-discovery facilitated as follows: "The process of work is a gentle flowing one – an organic event what goes on inside you, the therapist, and what goes on inside the child, in any one session, is a gentle merging".

In this way, awareness is the means by which the child regulates herself by her choices. In order to work through unfinished business, which clouds the choices available, the child needs to become aware of past hurts, fears, needs and resentments, and how they still influence the present.

Gaining awareness of needs and incompleteness is a primary step in therapy, facilitating healthy organismic self-regulation in the child. When a child is aware, she is also response-able (Yontef, 1993: 180). Attention must therefore be given

to help the child find suitable ways to satisfy these needs, this will enable the child to finish incomplete Gestalts in their lives. It is believed that the child intrinsically has the necessary energy and resources to satisfy their needs once they are aware of what they are, and the therapist therefore acts only as a facilitator during therapy with the child (Blom, 2004: 19).

- Awareness in group work

The focus of Gestalt group play therapy is to help the child to become aware of her process, i.e. what she does and how she does it. It is creating awareness of how the child identifies and then satisfies her needs. Yontef (1993: 139) describes awareness as the process of being in vigilant contact with the most important events within the individual and environmental field, with emotional, cognitive and energetic support.

Heightened awareness is created when the child is able to identify who she is, what she feels, what she likes and dislikes and what her choices are in getting her needs met. Aronstam (in Blom, 2004: 253) states that restricting experiencing to the here and now is the key to awareness when working with the child.

Awareness created during Gestalt play therapy must comply with three requirements (Blom, 2004: 253).

- It must be governed by the dominant need in the moment;
- There must be awareness of the present situation and how the child fits in to this;
- Awareness is sensorial and must be in the here and now as it happens in reality.

AIDS orphans who shut themselves off from the environment due to fear of “what is out there,” would benefit from group therapy by gaining awareness. Sensations and feelings, and identification of the self will strengthen their sense of self and self-determination thus allowing them to accurately identify and satisfy their needs.

### 3.3.2 Contact as part of the therapeutic process

Contact refers to being in touch with what is emerging here and now. It is through contact that we come to know others, but most importantly that we come to know ourselves. Contact takes place as soon as the child learns to use the environment to satisfy her needs. Oaklander (in Kaduson & Schefer, 2000: 29) states that healthy contact takes place when the child is able to make contact with the environment by making use of her senses. They are aware of, and are able to make use of their body. They are able to express emotions in a healthy manner, and this enables them to use their intellect in various ways to satisfy their needs. This dialogue is something that emerges when authentic contact is made and each person is treated as an equal, meaning what they say and saying what they mean, resulting in self awareness which enables effective conflict resolution (Yontef, 1993: 250).

In Gestalt theory, according to Korb (in Blom, 2004: 19), both intrapersonal contact, that between the child and aspects of herself, and interpersonal contact, contact between the child and the environment, are considered important for self-regulation to take place. Healthy contact, according to Oaklander (in Kaduson and Schaefer, 2000: 29), involves the use of the senses; looking, listening, touching, tasting and smelling, awareness of the body and use of the intellect. When any of these modalities are inhibited, restricted or blocked, good contact is inhibited. The contact boundary is the site where meeting and withdrawal take place. This is where growth and change take place. It is through contact-making and appropriate withdrawal that the child's needs are met and she grows. Boundaries must be penetrable in order to ensure exchange between the child and her field environment for this growth to take place. When the child's boundary is rigid and is not flexible, it impedes change and this may result in isolation. Oaklander (in Kaduson & Schaefer, 2000: 30) and (Blom, 2004: 20), found that if the child's sense of self is poorly defined, there will be no clear contact boundary and therefore problems will arise with making contact.

The relationship between therapist and client is most important. It is when this relationship grows out of contact that change can take place (Yontef, 1993: 126).

The therapeutic relationship is based on four characteristics of dialogue:

1. Inclusion: Demands putting oneself as fully as possible into the experience of the other without judging, analyzing or interpreting, while simultaneously retaining a sense of one's separate, autonomous presence (Yontef, 1993: 127). Inclusion provides an environment of safety for the client's self-awareness work and leads to change in both client and therapist.
2. Presence: This includes the expression of observation, preferences, feelings, personal experiences and thoughts that are shared with the client (Yontef, 1993: 127). This is not used however, to manipulate the client, but rather to encourage self-regulation as awareness deepens. The therapist has to be authentic and must be able to put into words what is experienced with the child (Curren, 1995; Seashore, 1995 Welp, 1995).
3. Commitment to dialogue: Contact is something that happens between people, something that arises out of the interaction. It cannot be forced and must just be allowed to happen (Yontef, 1993: 127). Brier (2000), states that this is the capacity of the therapist, to relinquish control of the meeting and allow what happens between the two to evolve.
4. Dialogue is lived: Dialogue between therapist and client is lived, not just talked about. This dialogue can be in any form; dance, song, words or movement of energy or what ever the child is comfortable with (Yontef, 1993: 27).

Once the therapeutic relationship has been established, it can be assessed whether the child is able to make and sustain good contact. This includes the ability to be fully present and integrate all aspects of the organism. This would include the body, the senses, the emotions and the intellect. Oaklander (in Kaduson & Schaefer, 2000: 29), states that when the child's senses and their body become restricted, as with a child who is frightened, grieving or angry, emotional expression and a strong sense of self will largely be absent as they inhibit healthy expression. Group therapy facilitates the full experience of self and other, and providing the child a platform on which to really experience herself.

If contact function is impaired, according to Perls (1971), the child gets trapped in what Perls refers to as a neurotic layer. Perls developed a theoretical construct of

the five neurotic layers to illustrate how fragmentation and resistance to contact prevented the experience of growth (Thompson & Rudolph in Schoeman, 2001: 92). The layers of neurosis as described by Perls are as follows:

- The phony layer, where children deny the problems and feelings that they have (Jacobs, 2004: 98). The AIDS orphan may pretend that nothing is wrong and that their parent will return soon. Introjects, such as that AIDS is a taboo subject and should not be discussed, can give the child the message that she should not discuss her feelings and losses either. She may even feel that she did something to deserve this and that this secret must be kept.
- The phobic layer, the child realises the actual state of affairs and this creates stress and tension for her as her reality hits home (Jacobs, 2004: 99). The AIDS orphan realises that her parent is not returning this time, but does not know how to express how she is really feeling. When she discusses her feelings in the group, she may be afraid because she is aware that she is not living in accordance with her introjects. She may be scared of what the group will do and think when she reveals herself beyond her false existence.
- The impasse layer is where the child is looking for external support to help her solve her problems. If the group does not acknowledge and help her with her bad feelings she may get stuck here, thinking that there is no way forward. She may become depressed and withdrawn, and may even refuse to return to therapy (Yontef, 1993: 13).
- The implosive layer, where the awareness dawns on how she has restricted herself from finding new strategies to solve her problems (Yontef, 1993: 14). Although she is still experiencing a lack of energy in addressing her needs in a healthy way the AIDS orphan may feel good about belonging to this group, feeling accepted and knowing she is not alone.
- The explosive layer, the realisation that she has the capacity to use her energy to own her emotions and to feel them. She experiments with new ways of being, finding new ways of adapting to the environment, and could even find healthy ways of meeting her needs. She therefore begins to own her unfinished business, and experiment with new behaviour, at first within the group and later "out there," in the world, using the energy that used to be tied

up in maintaining the phoney existence (Thompson & Rudolph in Schoeman, 2001: 92); (Blom, 2004: 252).

The ideal of Gestalt play therapy, therefore, according to Thompson and Rudolph (in Schoeman, 2001: 93), is to help the child grow, mature, take charge of her life and become responsible for herself through awareness and living in the here and now.

### 3.3.3 Contact boundary disturbances in therapy

Oaklander (1999) stated that contact involves the ability to be fully present in a particular situation, including senses, body, emotions, and intellect. The child may inhibit, block, repress or restrict various aspects of self. This may cause contact boundary disturbances, blocking the process of healthy organismic self-regulation. Should the AIDS affected child, according to Oaklander, have a poor sense of self, it will influence how she relates to others and the environment. The child may go in confluence, with no clear boundaries between her and the environment. She may intentionally try to avoid contact in order to protect herself from the stigma and prejudice she may experience. She may also project her own feelings onto others by blaming others for the bad things that have happened to her, simply because she is scared to take responsibility for her fearful feelings (Blom, 2004:249); (Kaduson & Schaefer, 2000: 30).

Some AIDS orphans retrofect, doing to herself what she would want to do to others (Yontef, 1993: 137). She may experience psychosomatic illnesses such as headaches or stomach-aches, suffer nightmares, engender self injuries or wet her bed masking her real feelings. She could also become obsessed with the symptoms of HIV.

Other children may deflect, denying the grief or anger they feel by being aggressive towards others or throwing temper tantrums (Yontef, 1993: 138). Blom (2004: 249) found that the child may also dream or fantasize as a way of avoiding contact with her emotions. She may experience a diminished sense of self and

thus be terrified that she will be abandoned, isolated or rejected, often an unfortunate reality for the AIDS orphan.

Group therapy will allow the child to become aware of how she operates in the world and also offer her the opportunity to try out new ways of being. The group may offer the security she needs as she tussles with her fragmented self.

Contact boundary disturbance occur when the child cannot maintain a balance between herself and the world. Her level of awareness is poor and she can no longer identify or respond to her needs. Contact boundary disturbances may lead to isolation, as when the contact boundary is fixed or impermeable, needs may not be met as close contact is prohibited. On the other hand, if the boundary is too flexible, the need to withdraw is blocked and confluence results. Confluence, according to Yontef and Jacobs (in Blom 2004: 21), is the loss of the experience of identity as separate from other. The child experiences herself and the therapist as the same, hampering the child's formation of self and blocking awareness (Schoeman in Schoeman & van der merwe, 2001: 31).

The child may inhibit, block, repress, and restrict various aspects of the organism in a bid for survival. The senses, the body, the emotions, and the intellect can be blocked and these restrictions become contact boundary disturbances that cause interruptions in the natural, healthy process of organismic self-regulation.

#### 3.3.3.1 Introjection

This occurs when the child takes in contents from their environment without criticism and awareness. Clarkson (2000) stated that the child sacrifices her own opinion and beliefs and simply accept the point of view of others, without questioning them (Yontef, 1993: 137). Introjects can be ideas, attitudes, beliefs or behaviour. They interfere with the child's natural process of organismic self-regulation and leave behind unfinished business. Introjects thus imply that the child absorbs aspects from the environment without considering the positive and negative impact they may have. Even though introjects do not actually become part of the child, they affect their functioning as if they were. The focus of therapy therefore, is to identify and examine these introjects that interfere with the child's

optimal functioning, and find techniques to help the child identify with, or reject them (Blom, 2004: 23).

Introjects negatively influence the child's self-awareness if the messages she get from a young age are that certain emotions are negative and should not be experienced or expressed. The child may then start living according to the labels she is given and repress her real feelings.

### 3.3.3.2 Projection

Projection is the tendency for us to hold the environment responsible for things that happen to us. Clarkson and Mackewn (in Blom, 2004: 24), found that this is often the case when the child has learnt that certain personality traits, emotions or behaviours are unacceptable. Projection allows the child to deny her own personal experiences (Yontef, 1993: 138). In these cases the child may tell lies and even deny her emotions. She has too little ego strength to take responsibility for her actions and she therefore blames others for the unpleasant events in her life.

Projections can be used in constructive ways. In therapy parts of the self are projected in the tasks in an attempt to help the child own their projections, so that their awareness and self-identity can be enhanced. In this manner contact with the environment is promoted in a self-nurturing manner.

### 3.3.3.3 Confluence

The lack of effective boundaries between the child and her environment keeps the child from making healthy contact with others. Latner (1992: 1) found that the child's identity becomes lost and her sense of self, that distinguishes her from the environment, becomes blurred as the child is no longer able to distinguish her own thoughts from those of others. Therapy is focused on helping the child to develop resilience, thus developing a strong sense of self, as she experiences making choices. Resistance occurs when a therapist tries to lead or heal the child, pushing thus leads to stagnation, as the more the child is directed towards a particular goal, the more she will fundamentally stay the same (Yontef, 1993: 27).



#### 3.3.3.4 Retroflection

Retroflection refers to behaviour that is done to self when we would really like to do it to other person or object (Yontef, 1993: 137). Clarkson states that the individual treats herself as she would actually like to treat others (Blom, 2004: 27). Retroflection occurs when the emotions and thoughts that are expressed by the child are not considered valuable by her caregivers. Sometimes the child is punished for expressing natural impulses. Anger is an emotion that is often retroflected. The child learns from an early age that expressing anger is prohibited. Oaklander (1999) found that the child often retroflects emotions of grief and anger through physical symptoms such as headaches, stomach-aches, asthma attacks or hyperactivity as these symptoms are more acceptable.

#### 3.3.3.5 Deflection

This refers to avoiding direct contact with other people, through avoiding eye contact during conversation, changing the subject or being polite instead of direct, result in reduced awareness of the environment (Yontef, 1993: 138). The child does not use her energy effectively in order to receive feedback from self, others and the environment, she simply attempts to avoid the impact of stimuli from the environment altogether. According to Joyce and Sills (2001: 11) deflection is a turning aside in order to avoid contact, thus blocking awareness.

#### 3.3.3.6 Desensitisation

This is the process by which we numb ourselves to the sensation of our bodies. The existence of pain or discomfort is kept out of awareness. The pain, according to Carroll and Oaklander (1997:190), is too overwhelming and therefore cannot be assimilated. The child deals with this pain according to her frame of reference and it remains there, unprocessed and unassimilated. Desensitisation, thus, implies that the child does not have sufficient sensory or physical contact with herself, and that she is therefore unaware of how she actually feels. She is therefore often unable to experience emotional contact-making because she cannot distinguish the physical experience from the emotional one (Blom, 2004: 30).

### **3.4 Here and Now as part of the therapeutic process**

The child is encouraged to explore immediate needs and unfinished issues, by means of an experiment. Unfinished issues from the past may emerge into the awareness continuum and into the foreground.

The here and now starts with current awareness, what is actually happening right now. The focus of Gestalt therapy is therefore on the present, prior events may be the object of present awareness, but these are processed in the now (Yontef, 1993: 149). This means that although the influence of the past, and predictions about the future cannot be denied, the only reality the child can work with in order to achieve growth, is right now, in the present, as past and present become condensed in the present moment (Chazan, 2002: 22). Group therapy allows the AIDS orphan to experience in the here and now, her anger, fear, or grief, as well as her physical pain and discomfort, in the knowledge that others experience the same feelings that she does. The group therapy process must stay with the process of each child, acknowledging the feelings in the here and now while providing support and understanding.

### **3.5 The I-Thou Relationship in the Therapeutic Process**

The I-Thou relationship involves the meeting of two people who are equal. The therapist, regardless of her age or training, is not better than her client. This particular way of relating focuses on responsibility. The therapist respects and honours each child in the group and is aware of her limits and boundaries, however, each individual is encouraged to be self-responsible. There is also the responsibility for the alliance between child and therapist, for which they both take responsibility (Yontef, 1993: 148). It is the responsibility of the therapist to meet, respect, accept and be genuine towards each child, and to instil this specific kind of relationship into the whole group (Blom, 2004: 254).

For the AIDS orphan, who may be withdrawn or feel different, building a trusting relationship with the therapist and the group, is imperative. In some instances the

relationship formed and the groups' acceptance may be curative. Respect, honour, genuineness and responsibility are essential components for the growth and self-acceptance of the of the AIDS orphan in group therapy.

### **3.6 Organismic Self-Regulation**

All matter strives for homeostasis. The individual identifies her needs and then tries to satisfy these needs, thus gaining homeostasis. The child normally reacts to trauma and loss in a manner consistent with her developmental level. She fears rejection and abandonment, and stresses when her needs are not met. The child may also take unrealistic responsibility for what has happened to her due to a lack of emotional and intellectual maturity. Oaklander (in Kaduson & Schaefer, 2000: 30) stated that the child who does not have her needs met could manifest symptomatic behaviour that would eventually lead her to therapy. The needs of the AIDS orphan may consist of some of the following:

- The need to understand how the disease is contracted.
- The need to deal with the pain and loss of their parents.
- The fear of stigmatisation.
- The need for proper nutrition and care.
- The anger towards the rejection they feel.

If the child cannot make contact with the environment to satisfy these needs, it may result in poor relationship building and thus poor contact, and may result in inaccurate information and self blame (Blom, 2004: 248). The group is the ideal place for the child's habitual ways of being to be discarded and for a new way of being, with full awareness of the presenting issues, to be experimented with (Yontef, 1993: 139).

### **3.7 Resistance in the Therapeutic Process**

Resistance is not an unwillingness to participate, but rather a lack of contact, and therefore insight, on the part of the child. Resistance can be considered as faulty contact with the environment. There is a lack of contact in terms of the senses, body, intellect, and emotion, which creates a block to real experience. Often the resistant child will resort to behavioural manifestations, Oaklander (in Kaduson & Schaefer, 2000: 29), states that this may be seen as their way of sidestepping the real issues in their lives. Resistance can however protect the child until she feels safe. The child manifests with resistance simply because she does not have enough inner strength to deal with her pain, it is important to respect this resistance until she has a strong enough sense of self to deal with the pain caused by unfinished emotions (Blom, 2004: 250). Group therapy will foster the child's process and encourage healthy acceptance of where she is in her grieving process, offering support and a climate which fosters personal growth. Bringing resistance into awareness allows the self-regulation of the child due to better contact and awareness (Yontef, 1993: 28). It is thus necessary for the therapist to do experimental exercises with the child, these will not only help to build the relationship but they also serve to promote self-awareness for the child (Schoeman in Schoeman & van der Merwe, 1996: 31).

### **3.8 Working with Polarities in the Therapeutic Process**

Polarities, according to Thompson & Rudolph (in Schoeman, 2001: 35), are seen as the conflicts and opposites which occur in life. The child may feel angry at their parents for having an incurable illness, but love and fear for them at the same time, they may respect the medical profession, but be angry with the doctors for having no cure, they may believe in Gods love, but also feel that he is punishing them for something.

For the AIDS orphan it may be a matter of wanting to show anger towards their parents for leaving them, but also having love and respect for them. The child will often repress their anger towards their parents because of a belief that a good

child does not experience these feelings. The child may find herself confused by experiencing feelings of love and hate for the same person (Schoeman, 2001: 36). This then results in fragmentation of her holistic self, since one part of her feelings must be denied (Blom, 2004:251). It is important to find ways to help the child to become aware of her fragmented polarities and to help her to find ways to integrate both feelings as part of her holistic self. Group therapy offers a safe space to experiment with this integration.

### **3.9 Dealing with Unfinished Business in the Therapeutic Process**

Most children have unfulfilled needs; Thompson & Rudolph highlighted the necessity to explore unexpressed feelings or incomplete situations with children in therapy (Blom, 2004: 251). Unfinished business from the past represents unexpressed feelings in the form of resentment, anger, guilt or grief, which is experienced as needless emotional debris that clutters present-centred awareness (Thompson, 2003: 72). The AIDS orphan may be angry with a parent who has left her, but may be unable to experience this anger or grief, because of the stigma surrounding the illness of the deceased parent. Group therapy will offer a platform for each child to work through their unfinished business in order that these denied feelings do not become “a monster” in their lives (Schoeman in Schoeman & van der Merwe, 1996: 69).

#### **3.9.1 Self-support**

The child must establish inner-strength through expression of the self; what she looks like, her likes, dislikes, choices and mastery of activities. A strong sense of self is imperative in order for the child to make good contact with her environment, enabling her to satisfy her emotions. Oaklander (in Kaduson & Schaefer, 2000: 30) and Blom, (2004: 255), noted that the child requires this self support, in order to own and therefore safely express her emotions. Self-statements are important, telling the therapist about who she is. It is important to gain self-support, a clear knowledge of one's self, before emotional expression can take place. According to Houston (1993:19) gaining self-support by expressing aggressive energy or by

mastery and having choices offered in the group setting, can assist the child in gaining or regaining a stronger sense of self, as the survival of each members' self is linked to the destruction or survival of the group.

### 3.9.2 Emotional expression

Oaklander (1988: 208) felt that it was important to assist the child in unlocking her buried emotions, helping her to learn healthy ways of expressing them. In order to unlock buried emotions, Blom (2004: 256), states that the AIDS orphan needs to get in touch with the feelings that she may be suppressing. She must learn to own these feelings and to express blocked feelings, such as anger, in a safe manner. The group must be a containing, safe place where it possible to express aggressive energy. Cushion fights, clay throwing, wet newspaper boxing, shooting darts at a token and tearing up newspaper are possible ways of expressing aggression in a socially acceptable way (Oaklander, 1988: 210). After projecting and owning their emotions, the AIDS orphan must be assisted to use new strategies for handling her emotions in the future (Blom, 2004: 258).

### 3.9.3 Self-nurturing

Many children digest faulty messages about themselves, as they do not have the maturity and cognitive ability to filter the truth about self. Oaklander (in Blom, 2004: 258) discusses how negative introjects inhibit the growth of the authentic self, and this naturally interferes with their healthy emotional development. Self-nurturing is the task of accepting those hateful parts of one's self, working towards self-integration and a sense of self-worth, culminating in the acknowledgment of the authentic self. Schoeman (in Schoeman & van der Merwe, 1996: 181), feels that the child needs to learn how to become more accepting, caring and nurturing towards herself in order to reach her true potential.

The AIDS orphan may believe that she has done something wrong and that her parent's sickness and abandonment is punishment for these wrong doings. The child can be helped to become more nurturing towards herself, through the use of projective techniques, in order to clarify what she needs to take responsibility for.

Blom (2004: 259) recommends that she do something nice for herself every day. The AIDS orphans' sense of self may have been diminished due to the stigma coupled with feelings of loss and grief. This will hamper her ability to identify and locate some way of satisfying her needs adequately, however, the group experience may help her to rediscover these aspects of herself (Blom, 2004: 260).

### **3.10 The Bereavement Processes in Therapeutic Work**

- **The Physical Process**

In bereavement, according to Anderson, the child expresses physical and emotional responses in anticipation of a loss and/or during and after a loss (Doka, 1995: 63). The effects of loss may be described as a hollow feeling in the stomach and tightness in the chest and throat. Worden (in Blom, 2004: 224) found that the child may be sensitive to outside stimuli and may experience a shortness of breath. Weakness in the muscles and a lack of energy are observed and the child may complain of a dry mouth.

Gestalt play therapy creates a space where the actual physical symptoms are experienced and worked through with the facilitator. Dialogue, for example, may be used to allow the hollow stomach to speak with the tight throat, or whatever the arising need is. The AIDS orphan is thus given the chance to really feel her emotional pain by confronting the physical pain she feels.

Loss of physical assets and her home are also a reality for the AIDS orphan. Livestock and land is often sold or stolen by relatives (van Dyk, 2005: 269). Richter observed that due to the lack of adequate care and availability of health services, the AIDS orphan may become malnourished and ill, adding to the high levels of stress with which she lives (Pharoah, 2004: 12).

The extended family is not a social sponge with an infinite capacity to soak up orphans. Foster (in Pharoah, 2004: 70) found that some children slip through the net and end up in extremely vulnerable situations. These could include living and

working on the street or living by themselves with their siblings in child headed households.

HI virus has an effect on the child's physical development. When the child suffers from persistent coughs, skin lesions, diarrhoea, ear and throat infections and weight loss, the repercussions can be enormous. If the child is persistently tired, she may be unable to participate in physical activities, usually encouraged during this developmental phase, and this may affect her social interactions, emotional wellbeing and peer support (Blom, 2004: 243). The HIV positive child is also dependent on healthy nutrition, personal hygiene and exercise, which caretakers need to provide.

- The Cognitive Process of bereavement

In bereavement, according to Anderson, the child needs to understand what is happening and what has happened to her and her loved ones (Doka, 1995: 63). The child experiences the same thought patterns as adults; Worden (in Blom, 2004: 224) states that the child experiences initial disbelief, confusion, reliving, imagination and even hallucinations. The child experiences changing thought patterns during the different phases of the grieving process and these could manifest physically in fixations. Some children think that the death of their parent is their own fault (Blom, 2004: 225). These normal reactions are exasperated by the fact that the parent died as a result of AIDS. When someone is discriminated against due to fear of the HIV/AIDS virus, the whole family suffers (Positive People, 2001: 33). The child and the family's own sense of stigma, guilt or failure may reinforce a desire to keep one's HIV status a personal or family secret. The risk of discrimination, according to Anderson, makes this secretiveness understandable and perhaps necessary, but it can also result in isolation that complicates the emotional issues facing the child and her family (Doka, 1995: 60). In addition, Richter (in Pharoah, 2004: 11), felt that stigmatisation may actually prompt the affected child to stay away from school, rather than endure exclusion or ridicule by teachers and peers. The child is likely to drop out of school due to financial difficulties, illness and the social stigma of parents dying from AIDS. Often the child does not attend school because her guardians are unwilling to incur the costs involved in sending her to school (Ghosh and Kalipeni, 2004: 311).



Anderson observed that a child whose parents has AIDS has a high probability of being orphaned - an emotionally formidable challenge, for any child, made more dangerous by the nature of the illness, and frequently the poverty and discrimination of the stressed out community of which the child is a part (Doka, 1995: 62). This secretiveness, according to Anderson, could increase the child's apprehension, as they are aware that something is happening, but the cause and consequences are not clarified for the child. In this atmosphere, Anderson states, the child is free to create and imagine a range of frightening possibilities, including blaming herself for her family's misery (Doka, 1995: 63).

Healthy children in middle childhood normally become enthusiastic learners, since perception, memory and integration, become differentiated and more prominent. Wordrich & Swerdlik (in Blom, 2004: 245), stated that the psycho-educational implications for AIDS infected children, such as school absenteeism, adjustment to medical regimes, stigma and isolation may result in developmental decline, language problems or neuro-psychological deficits.

- The Behaviour Process in bereavement

A grieving child is helped by a formal or informal commemoration of the loss of the loved one. The rituals that encourage remembering and community support are often expressed in the context of religion. However, according to Anderson, the death of a loved one may also be accompanied by a spiritual melt down where the child questions her spiritual life and religion (Doka, 1995: 63). Sleep and eating disturbances, memory loss, social withdrawal, avoidance of memories and searching behaviour are all common reactions to loss. Sighing, restless behaviour, weepiness, wearing mementoes and keeping precious objects are some of the behaviours that can be expected. This could be explained as deflection where contact boundary disturbance takes place and this restricts the satisfaction of needs, causing an imbalance (Blom, 2004: 225).

The child may also be expected to carry at least some if not an inordinate burden of responsibility for the family. Anderson found that this might include performing physical tasks, as well as providing attention and emotional support and supervision for other children and sick parents (Doka, 1995: 62). In certain

circumstances, Richter (in Pharoah, 2004:10), found that work and responsibility are being given to children as young as five years old. These may include domestic chores, subsistence agriculture and provision of care giving to the very young, old and sick members of the household.

AIDS orphan girls living in cities and rural areas, have increasingly joined street children and have become heavily dependent on commercial sex for survival as the AIDS epidemic has brought with it a crisis in foster care (Ghosh & Kalipeni, 2004: 312). As the AIDS pandemic has worsened, the number of orphans has increased dramatically, putting the traditional child foster system under considerable strain. Traditionally, when parents die, the child is sent to live with another member of the extended family, but the challenge of absorbing ever-increasing numbers of children into households that have limited resources has surpassed the material ability of most households (Ghosh & Kalipeni, 2004: 313).

The growing number of street children indicates that the extended family system is over-stretched and unable to provide support to AIDS orphans.

- The Emotional Process in bereavement

Trauma will be exacerbated by the stigma and secrecy, which is felt when someone dies of AIDS. This hampers the bereavement process and exposes the AIDS orphan to discrimination within her community or even her extended family, depriving her of emotional support structures (Pharoah, 2004: 3). Coping with death and dying has a major impact on the child's resilience and affects her ability to cope with her circumstances. When the child is attended to emotionally, she is better able to use the opportunities available to her for education, health and other aspects of her well-being. Giving the child food and clothing is not enough. Many families are already stretched, coping with death and severe poverty, and no longer have the capacity to meet the orphaned child's emotional needs (Jewitt, 2001: 12).

Killian (in Pharoah, 2004:33), describes resilience as one of the greatest puzzles of human nature. He said that resilience appears to be an ordinary magic that enables some children to progress well despite difficult circumstances. He found

that the resilient child trusts and enjoys secure attachments to others. She is confident that people will be there for her, and as a result she seeks and finds emotional support and is confident of her right to such support. She is able to relate to others in a positive manner and has the ability to see humour in difficult situations. Killian also found that the resilient child was able to discuss difficulties with people whom she trusted and respected (Pharoah, 2004: 46).

The grieving process, according to Anderson, includes learning how to go on with one's life. Learning to reconstruct one's life, however, requires the support of caring adults. The child needs to create a sense of meaning through what she has experienced. She needs to recognise her ongoing identity and purpose in life in spite of her tragedy (Doka, 1995: 62).

The HIV/AIDS pandemic has the potential to undermine family structures. The orphan is stressed even before her parents die. Dhlomo stated that the death of her parents from HIV/AIDS exacerbated her feelings of depression, anger, resentment and confusion (AIDS orphans in Africa, 2001: 53). In most instances, the child has already been traumatized by having to care for her sick parents, who have now died. The loss of income due to the bread winner's terminal illness, parenting siblings and being farmed out to extended family members who may already be battling to cope with their own poverty increases the trauma experienced by the AIDS orphan. Many of these children are forced to leave home and end up on the streets (Mckay, 2002: 26).

During play therapy the therapist offers the child the opportunity to make contact, thereby integrating the fragmented parts of herself. Emotional expression is the essence of any therapeutic process, and it is through emotional expression that the child begins to support herself. The child is offered the opportunity to recognise, to own and to express emotions so that unfinished business may be dealt with. In some cultural customs and child rearing methods, the child is actively discouraged from experiencing or expressing her emotions, this leads to loss of cognition, which is one of the most important factors in the facilitation of change (Blom, 2004: 227).

The child in middle childhood learns to express emotion, control it, suppress it or hide it. Van Dyk (in Blom, 2004: 245), felt that fear seems to be the emotion most relevant to the AIDS orphan. During this phase they may already express fear of the supernatural, monsters, darkness, lightning, physical injury and death as well as respond to media reports or awareness programs on HIV/AIDS. When the child is not given the opportunity to talk about death and dying, her imagination and fear take over in response to the emotions she sees around her and she may assume responsibility, feel powerless and angry with herself for having caused this problem (Jewitt, 2001: 12). The child who is bereaved by AIDS often has to cope with not only being orphaned, but also with multiple deaths in her family, the secrecy, stigma and many misconceptions still attached to the disease as well as extreme poverty (Jewitt, 2001: 13).

- Social development of the bereaving child

Family support, community structures, school and friendship networks are important for the child in the middle childhood years. Poverty, a lack of resources and poor treatment may influence the AIDS orphan's developmental progress. A preoccupation with illness, poor body image and hopelessness often occurs when the child is left to care for herself. Risk-taking behaviour, conduct and hyperactive disorder may manifest themselves as a result of neglect. Repeated hospitalization for the HIV/AIDS infected child results in increased isolation from her peers and may have an adverse effect on her social, cognitive and communicative development. Extreme stress in the family may even lead to abuse, neglect or abandonment of the AIDS orphan. Often the lack of knowledge of the plight of the child leads to increased and extended suffering.

Group therapy may provide the AIDS orphan with a forum for healing where she can experience being heard and the acceptance of other grievers.

### **3.11 Group Therapy with HIV/AIDS Orphans**

The most important area of concern of Gestalt therapy is that which the adult or child is feeling or experiencing at the moment. Oaklander describes Gestalt

therapy as a humanistic, process orientated therapy, which is concerned with healthy functioning of the total organism, which includes all senses, body, emotions and intellect (Blom, 2004: 247).

Oaklander (1978: 285) states that one of the main advantages of group work is that it provides an insulated world where present behaviours are experienced and new behaviours may be tried in relative safety. Each child has the opportunity to participate actively or simply to listen to the experiences of the other members of the group. The group becomes a place where each child becomes aware of how she interacts with other children, it is in the group that she learns to take responsibility for what she does, and it provides a space for experimenting with new behaviours. It is a place where she will meet and come to know other children with similar feelings and problems (Oaklander, 1978: 288). The healing dimension of a group for AIDS orphans comes from the experience of being heard and accepted by other grievers (Dane, 2002: 265).

### **3.12 Appropriate Techniques for this Study**

Techniques give the child an arena through which self-discoveries can be made. Awareness is enhanced during the experience of a projective task. The techniques used by Oaklander (1988), for therapeutic experimentation are modified for this specific study. The application of the Gestalt therapeutic principles in this modified technique will be discussed in the following paragraph.

#### **3.12.1 The memory box technique**

The role of memory in the bereavement process is widely acknowledged. The concept of memory boxes is not a new one either. It was used successfully in the facilitation of legacy-leaving by parents dying of HIV in Uganda in 1997 (Denis, Pilot Study, 1). The memory box will be used in this study, as a technique in group therapy, to contribute to the process of memory retrieval and the creation of the child's own narrative, individual legacy or story. After parents die, many orphans live in foster care or alone, cut off from their family. Their personal history quickly

fades and the child is at risk of growing up without a clear sense of her identity and roots, without the traditional beliefs of her heritage (Children First, October 2003).

On the one hand, memory box work involves a very private and personal journey, but it also offers the opportunity for the child to have her life witnessed by considerate, understanding and caring others (Morgan, 2001: 4). The process of memory box creation helps to encourage sharing of stories between group members, thereby breaking the silence surrounding AIDS. The memory box also creates a space to talk about the sickness, death and feelings that the child is left with after her parents have died (Denis, Pilot Study, 4). The memory box may promote resilience in AIDS orphans as the bereavement process is encouraged and the stigma often associated with AIDS is removed.

Techniques used in Gestalt play therapy involve self-expression through projective media. Interpretation is never part of a Gestalt therapy process. Successful therapy with a child lies in enabling the child's own deeply rooted wisdom.

The role of the facilitator is to assist the child to remember her parents in a positive way, helping her to build an identity and strengthen her emotional capacity. The facilitator also assists the child in understanding her past and enabling her to be less afraid of the future (Children First, October 2003).

The memory box includes materials that will sensitise the child's senses. Each session will include an aspect of each sense, fostering memory and enabling the child to revisit the past in the form of boxed narrative therapy. The act of focusing special attention on the containers for the memories represents an opportunity to protect, make space for and attach added value to the processes of story telling (Morgan, 2001: 6).

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#### 3.12.1.1 Owning the projection

Feelings must be recognised as part of the self. Frequently in a projection, real feelings, which emerge from unfinished issues, need to be integrated. At this point the child often offers resistance. The exploration of polarities is recommended to

neutralise the resistance and to encourage choices. What is felt during the projection must be tested against reality and strategies of containing or dealing with these feeling implemented.

Exploration of polarities leads to the identification of alternatives. As the child is made aware of different positions, she needs to be made aware of her choices. Consequence of choices may be explored further through another projection or discussion, depending of what the child needs. According to Schoeman (2002) as the child takes ownership of what was externalized through a projection, her own competence is affirmed.

### **3.13 Conclusion**

In Chapter three the therapeutic considerations were introduced. The researcher postulated that Gestalt play therapy is a suitable medium for intervention in order to empower the child to release energy as part of an ego strengthening process.

The challenges facing AIDS orphans in South Africa are formidable. The memory box will allow each child the opportunity to tell her story in an age-appropriate manner. The child will be encouraged to use whatever is available to her to recreate memories and to store them in a box to be revisited when she feels the need.

In Chapter four the empirical data will be described and analysed to determine whether the Gestalt group therapy using the memory box technique, is effective in the treatment of AIDS orphans.

# **CHAPTER FOUR**

## **METHOD OF INQUIRY AND INTERVENTION**

### **4.1 Introduction**

The procedure to be followed in conducting this study will be introduced in this chapter. In Chapter one it was outlined that using case studies in a group setting, within the Single-Systems Design, was the strategy best suited to obtaining the information about the phenomenon. Group Gestalt play therapy, with the memory box as the medium, was the process of facilitating intervention used with the children orphaned by AIDS.

### **4.2 The Research Process**

Research activities were conducted by means of the steps indicated by Strydom (2002: 150), using the Single-System Design. The single-system is, according to Barker, Salkind and Williams (in Strydom, 2002: 151), the ideal way of evaluating the effectiveness of treatment interventions. This makes it a useful method of ascertaining the effectiveness of Gestalt group play therapy for AIDS orphans in middle childhood phase of development. In the Single-System Design, multiple measures are taken from a single participant over time. Each group member completed the Piers-Harris children's self-concept scale psychometric test, during the first session, which serves as a baseline measure. The total self-concept was measured as well as five domains. The following domains were assumed to indicate the level of self-concept and were also measured; physical appearance and attributes, intellectual and school status, happiness and satisfaction, freedom from anxiety, behavioural adjustment and popularity. The same test was then repeated during the final session. A comparison was made between each individual's pre-treatment, baseline scores and her post-treatment scores to evaluate the effectiveness of the program. The Single-System Design, therefore,



involves the planned comparison of observations in a pre-intervention period with observations during the intervention period and re-testing during the post intervention period (Strydom, 2002: 156).

#### 4.2.1 The A-B-A design

The measurement instrument, in this case the Piers Harris children's self-concept scale, (A of the Single-System Design), was used before the treatment phase (B), and again at the end of the treatment phase to measure any changes in the self-concept of AIDS orphans. Each group member was individualised and her self-concept measured before and after the treatment manipulation. The comparison, thus, was between each individual child's pre-treatment and post-treatment scores (Strydom, 2002: 158).

#### 4.2.2 Advantages of the Single-Systems Design for this research

The following advantages, with reference to Strydom (2002:161), of using the Single-System Design for the evaluation of the effectiveness of Gestalt group play therapy with AIDS orphans using the memory box as a medium are listed:

- All participants, AIDS orphans, in the group received the treatment intervention. There was no control group and therefore no child was excluded from the therapeutic group. The use of the Single-System Design therefore avoids the ethical issue of inferior treatment for some participants.
- The Single-System Design is a low-cost design, and the researcher conducted all testing and group sessions.
- The Single-System Design is direct and the results were available on completion of the group sessions.
- Due to the fact that each child in the group was viewed as an individual, the information that may have been lost in a group comparison was preserved.
- The Single-System Design is easy to use and did not disrupt the therapeutic aspect of the group.

- The Single-System Design is suitable for Gestalt group therapy, as modifications in the intervention were possible, which allowed for the “experiment” which defines Gestalt therapy.
- The Single-System Design is effective in evaluating intervention programs, and it offered good feedback from the orphans in terms of how valuable the program has been for each one.
- The Single-System Design allowed for the researcher to collect, rich qualitative information, as each AIDS orphans process will be noted within the group setting.

#### 4.2.3 Disadvantages of the Single-Systems Design for this research

The following disadvantages, with reference to Strydom, (2002: 162) of using the Single-System Design for the evaluation of the effectiveness of Gestalt group play therapy with AIDS orphans, using the memory box as the medium can be listed:

- In order to ascertain whether the Gestalt group therapy has been responsible for an observed change in the AIDS orphans, all other variables should be controlled. Since the variety of variables in everyday life cannot be controlled, it may appear artificial.
- Due to the duration of the group sessions, this Single-System Design can be time-consuming.
- The Single-System Design does not have a control group and thus may not be as valid as a well-designed group study.
- Generalizations to all AIDS orphans in the middle childhood phase of development can not be made, as no comparison group is available from which to draw conclusions.
- Follow-up studies with the AIDS orphans will need to be conducted in order to evaluate the long-term benefit of the intervention program

### **4.3 Steps in the Single-System Design as Applied in this Research**

Although already discussed in Chapter one, the following steps for a Single-System Design as described by Strydom, (2002: 154) will be elaborated on:

#### **4.3.1 Formulate the problem:**

With the death of a parent or the loss of a caregiver, and therefore the loss of their support structure, the AIDS orphan experiences many traumas, which may lead to a loss of sense of self. Through the process of making and filling the memory box, she will be empowered to restore her sense of self, connect with her past and tell her story, enabling her to deal with her loss more effectively. The research will be based on the assumption that the process of putting together a memory box, including photos, drawings, a family tree, fabric and anything else that reminds the child of her parents and helps her to tell her story, will offer the child something tangible to visit during times of need. The focus is on bringing the past to the present, thereby enabling the child to work in the here and now, aiding the grief process. The unit of analysis was the individual child's self-concept, in a group setting.

#### **4.3.2 Identify selection criteria (as stated in Chapter 1)**

- The children selected were in the middle childhood phase of development, and between 7 to 10 years of age.
- AIDS orphans (The child will have lost one or both parents due to AIDS).
- Able to work in English.
- Not previously being referred to play therapy.

#### **4.3.3 Selecting the participants**

The target sampling method was used in selecting the participants for this study. The staff at Johannesburg Girls Preparatory School compiled a list of ten known orphaned children in the middle childhood phase of development. Each child's guardian was contacted and her parent's cause of death was established. Permission was obtained from the guardians of the five suitable children, for them

to attend the therapeutic group. This method was used due to the difficulty in identifying these children in communities where AIDS is still a closely guarded secret. Language difficulties were also controlled in this way as these children are schooled in English.

#### 4.3.4 Review the literature

The literature reveals that the child in the middle childhood phase of development has specific development tasks and challenges. It is a time when a secure home environment is essential in order for her to focus her awareness and energy on fulfilling these tasks. The child orphaned by AIDS struggles to collect her fragmented self, and is therefore often unable to attend to her developmental needs. It seems, according to Morgan (2001: 2) that the act of focusing attention on the physical box for the memories represents an opportunity to protect, make space for, and attach value to the process of telling the story.

At an age when the elderly expect support from their children, they have to bury them instead, and are often forced to take responsibility for their grandchildren. Due to this, neither the caregiver nor the child, know how to talk about what has happened. Memories of the parent fade, especially when the child is prohibited from talking about them. A state of confusion often remains, preventing the child from developing her full potential (Denis, 2001: 2). It is therefore assumed that the child who remembers her parents in a positive way will be in a better position to deal with the hardships of her present circumstances. It is important to break the silence around AIDS in order to facilitate the child's resilience. This intervention was intended to give the child permission to talk.

The Piers Harris children's self-concept scale, which was used before and after the intervention, measures self-esteem and self regard which reflects the child's sense of self.

#### 4.3.5 Develop goals and objectives

The research was applied research as the objective was to explore and describe the Gestalt play therapy process using the memory box as a medium. Both quantitative research, in the form of a standardised self-concept test, and qualitative research, in the form of describing the experience were used, offering knowledge and solutions.

This was evaluative research, as the aim was to assess the applicability of using the memory box as a medium in Gestalt play therapy groups with AIDS orphans in the middle childhood phase of development.

- The goal of this research was to ascertain the value of Gestalt group play therapy for the individual child who has been orphaned by AIDS. The intervention was applied to the whole group, and each individual was monitored within that group system. An increase in the child's self-concept or aspects thereof was the gauge of success.
- The research also indicated the effectiveness of using the memory box as a medium during the intervention, as a means of aiding grief work and of fostering a renewed sense of self through support and removing the stigma often associated with AIDS.

#### 4.3.6 Develop the hypothesis

This research was based on the hypothesis that the process of making and filling the memory boxes, within a Gestalt play therapy group, will lead to a restored sense of self, linking the child to her past. This will lead to a change in how the child feels about herself and the situation that she finds herself in.

#### HYPOTHESIS:

*The making of memory boxes in Gestalt group play therapy sessions will empower the AIDS orphans, aged 7-10 years old, increasing their self-concepts, resulting in a restored sense of self.*

#### 4.3.7 Develop the design

Collaboration was sought from the Johannesburg Girls Preparatory School as it was felt that it would be beneficial to run the groups at school, during school hours, thus alleviating problems regarding transport.

The staff at Johannesburg Girls Preparatory School identified children who had been orphaned during the past two years. The guardian's were contacted and details regarding the status of each child were obtained. Letters were sent to the guardians of these children, requesting consent for the children to take part in this research, through attending the Gestalt play therapy group sessions. The group activities were designed to help the child to experience, and come to terms with her, thoughts and feelings surrounding her parent's death. Creative arts, rituals and story telling, were used in this group setting together with sensory stimulation, in order for each child to re-experience and share her grief with the others within the safety of this group.

The child often needed to work alone within the group, as her processes are unique to herself. She was however, encouraged later to share and interpret her work within the group. The group activities were designed to promote dialogue and to assist the child in understanding and processing the complex problems related to being an AIDS orphan (Webb, 2002: 276).

The memory box was used to store and protect the precious, real and symbolic memories of the deceased parent. The child worked with her memories through story telling, drawing, and the sharing of tangible memory items. The sharing of experiences and thoughts were felt to be important as she again had an opportunity to grapple with the reality of her own story. The memory box was decorated by the child, and became her own unique treasure box, holding the memory items of her parent. Webb (2002: 276) suggests that in the event that the child lacks a clear memory of her loved one, she could be encouraged to explore her feelings associated with this loss and to talk about her dreams, where possible she may even create memories from the trace memories she has.

Rituals were used to create a safe and special place for the expression and sharing of the intense emotions associated with being an AIDS orphan. The opening and closing rituals, at the beginning and end of each session, helped to set the tone for the group, and enabled each member to share where she was in the process at that moment. A break mid way through each session was taken. Food and drinks were shared as this created an additional feeling of the nurturing and acceptance within the group.

Games and exercises also formed an important aspect of group therapy. Segal (in Webb, 2002: 276) recommended that games and communication exercises be incorporated into group therapy as this helps the child express her feelings related to her loss. Art techniques, including crayon drawings, clay, or hand puppets, were available for use, to help the child to portray her feelings and conflicts. Poppen and Thompson (in Webb, 2002: 277) described how group activities enhance self-concept when one focuses on the child's strengths during group sessions. These activities were used in the group during each session, as enhancing the child's self esteem was an important part of the group process, as was enhancing the child's coping skills.

Grief is a natural and normal response to loss, unfortunately Doka (in Webb, 2002:277), found that the AIDS orphan is often denied this because of their feelings of shame, and the social stigma which frequently accompany AIDS related deaths. The child often feels embarrassed or has learnt to remain silent, out of fear of being rejected or ridiculed, by the very people she is relying on to take care of her. Often the child is left feeling lonely and isolated, unable to visualise a future for her self. Group therapy provided the bereaved child with a safe and supportive environment in which she could express issues kept secret in her family. The child received support from her peers and the group leader and co-leader; this was possibly the only time that it was safe enough for her to talk about the deaths have impacted severely on her life.

Prior to the first meeting of the group, each child's guardian was contacted and consent given for the child to attend the group. Information regarding demographics, parent's history of AIDS, disclosure process, age of parent, date of

death, funeral service, and the child's preparation for the death and post death reactions were also noted where available.

Group sessions were held at Johannesburg Girls Preparatory School on Monday and Friday mornings from 8.00 to 10.30 each week.

#### 4.3.8 Define the dependent variable

The dependent variable is the child's self-concept, indicating the child's sense of self which is assumed to relate to the child's resilience and ability to cope with being an orphan through AIDS. The researcher observed the changes in the child's perception of her own behavioural adjustment, intelligence and school status, physical appearance and attributes, anxiety levels, popularity and levels of happiness and satisfaction. The facilitator measured these changes using the Piers-Harris children's self-concept scale and through describing observations made during each session.

#### 4.3.9 Define the independent variable

The independent variable was the intervention program, the group sessions where the memory box as a medium was used with AIDS orphans in the middle childhood phase of development. The group was a closed group and the six sessions were semi-structured and are described in detail under intervention phase below.

#### 4.3.10 Determine obstacles

- Children dropping out of the group or missing one or more sessions due to being absent from school on the day of the session.
- The group sessions were conducted in English. The home language of all participants is not English, however they are all schooled in English.
- Piers-Harris children's self-concept score is based on children in the USA and may not be accurate for South African children.



#### 4.3.11 Baseline phase

Each child was assessed using a quantitative measure prior to the intervention to their baseline self-concept score. The Piers-Harris children's self-concept scale was used to measure the total self-concept of each child. The six domain sub-scales were also explored.

The sub-scales included:

- Behavioural adjustment.
- Intellectual and school status.
- Physical appearance.
- Freedom from anxiety.
- Popularity.
- Happiness and satisfaction.

The respondents were asked to indicate whether each of the 60 statements in the scale applied to them by indicating "yes" or "no". The 60 questions are statements expressing how people feel about themselves.

#### 4.3.12 Intervention phase

Data capturing during Gestalt play therapeutic intervention through observation and the description of each child within the group. The intervention took the form of a closed semi-structured group, which met for six sessions.

The group sessions were as follows:

##### 4.3.12.1 Session one - Introduction and relationship building

The leader and co-leader of the group introduced themselves to the group. Each child introduced herself and name stickers were used as an easy method of getting to know each other.

Members of the group were:

Leigh-Anne: Facilitator

Faye: Co-facilitator

“T”: Eight years and one month old, female, living with her granny, she has an older sister.

“C” Seven years and ten months old, female, living in foster care.

“A” Nine years and one month old, female, living with her granny.

“Y” Eight years and five months old, female, living in a boarding house.

“M” Eight years and eleven months old, female, living with her granny

### PRE-TEST

The children were asked to complete the questions on the Piers-Harris children's self-concept scale. Question had to be read to “M” as we found that she could not yet read.

The groups' expectations were explored and group rules laid out by the group members as follows:

Confidentiality

Attendance

Allowing one person to talk at a time

Listening to each other

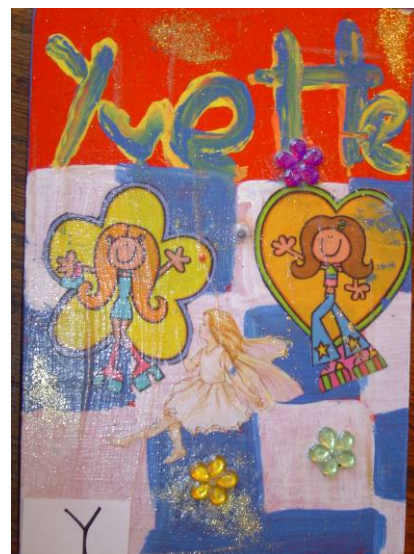
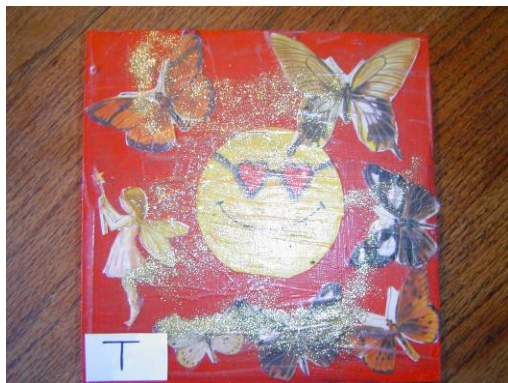
Respect

- The leader asked if anyone knew why they were in the group. As no one knew the answer, she explained that all members of the group had no living parents.
- The children were told that we will be meeting twice a week on Monday and Friday mornings for the next three weeks.
- This first session was a very important one as the relationships established here set the atmosphere for the remaining group meetings. At this session members decorated their boxes, this provided a fun forum in which the children connected to the group, and it served to foster a feeling of safety and security among the participants.

The group shared drinks and snacks while chatting about the group and what they were doing in it.

An important aspect of this first session was to provide the opportunity for each child to tell the group a little about herself including information with regards to where they are living and who takes care of them. The leaders demonstrated both empathy and listening skills. The group members were also encouraged to respond to each member's story sensitively.

In closing, members were asked to share their feeling about the session. They all experienced the decorating of the memory box as very enjoyable. "Y" expressed surprise at the fact that all members have no mothers, the others were also amazed that they were not the only ones. A brief outline of the next session was given to enable the members to bring items from home should they wish, and to prepare the children for the work ahead.





Memory Boxes

#### 4.3.12.1 Session two - Exploration of Relationships Before and After Death

The group began with sensory work. A selection of coloured cellophane paper was available. The children were asked to choose a colour that indicated how they were feeling after the weekend.

Once all members had reported on their weekends, two types of essential oils, tea tree oil and lemon grass oil, were passed around for each member to smell. Tea tree oil was used as it has a medicinal smell. The members were encouraged to comment on what the smell reminded them of.

The group was then asked to draw a picture of their parent while they were sick, just before they passed away. This appeared to be the first time that the children have been invited to discuss their parent's death, this caused a level of anxiety and therefore the leader asked the group to close their eyes and form a mental picture of her parent.

Each child then used the picture to tell her story about the time before her parent died. "T" said her mother was taken to hospital because she had sores on her face and she just died. "A", "C", and "E" all said that they had helped their moms while they were very sick. "C" and "A" were visibly disturbed and the colour drained from their faces as they spoke about their mom's illness. The leader had to remind

members to listen carefully to each other's feelings and thoughts, and to help each other.

The leader explored the relationship that each child had had with their parent and what they missed the most about their parents. All five children missed the kindness of their parent and also the clothes that they used to buy them. At no time did any of the children refer to HIV or AIDS. This may indicate that the "conspiracy of silence" which surrounds the AIDS orphans is very real.

The reaction of "A" and "C" may indicate that they both internalise their pain, leading to physical symptoms rather than verbal expression. "Y" was very sure that she missed her mom's kindness but said that she was fine. "T" and "M" were distracted and needed countless visits to the bathroom. This resistance is expected when dealing with issues of this nature. They were given the time and space that they needed.







### Parent sick at home

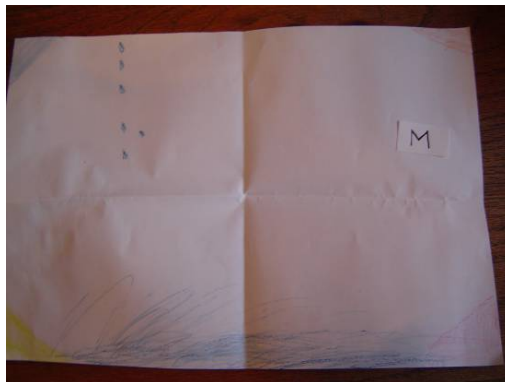
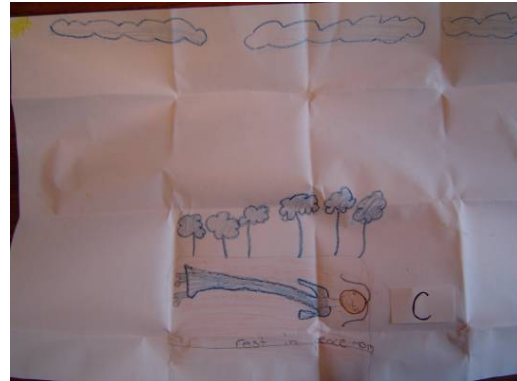
Refreshments were shared and this came to be an enjoyable time to discuss what food and drinks we enjoy and what we did not like to eat and drink.

The children were then asked to draw a picture of something that they remember from the day of their parent's death or funeral. Once again they were encouraged to become aware of what they could smell during that day. "T" did not want to draw this picture. The other children drew their pictures but felt that they would prefer to talk about these pictures at the next group.

All the group members believe that their parents are with God or Jesus; "T" said that she was concerned because she saw then put her mom underground. "M" agreed and said, "God was up but they put them down". The group discussed how the "boxes are placed in the ground, but that the person goes to God". It was felt that some reflection time would aid the exercise and the pictures were placed in the memory boxes to be discussed at the following session.

The group then talked about how they experienced talking about their parents in this group setting. "Y", "T", "A" and "C" said it had been a good experience and that they felt good to be able to talk about their moms, as they did not have opportunity to do this elsewhere. "M" said she did not want to talk about mom and wanted to "just forget about it." This reaction is possibly due to the fact that she

had lost both her parents within a month of each other in June 2006, and that she appears to be developmentally delayed making it difficult for her to process and express her feelings.



### Funeral Pictures

#### 4.3.12.3 Session three - The Impact of the death for each child

The session began with a sensory exercise. The children closed their eyes and listened to a piece of music. A discussion took place as to what they could hear in this music; triangles, piano and wind instruments were identified. The children then described how the music made them feel. They all reported feeling happy and relaxed. "Y" has become the leader of this group. The others look to her for ideas and confirmation.

Each child was invited to choose a puppet to tell their story about the drawings of the funeral that they had drawn at the last session. “Y” began the discussion, she had chosen to be a nurse puppet, and remembered when “they put the sand on the box”. She felt sad, but was comforted by her aunt. “C” chose a donkey to represent herself. She found this exercise very difficult and spoke very quietly with her fingers in her mouth. She also rocked from side to side and said she could remember that it was a sunny day and they ate cookies and drank juice. She recalls feeling sad but does not remember being comforted. “A” chose the panda puppet. She was very shy and covered her face with the panda. When discussing the funeral day she hit the picture repeatedly with the panda. Her sister was with her and comforted her. They ate cookies and drank juice. “T” chose a hedgehog and remembered eating rice and meat. Her granny was with her and gave her a hug. “M” was sick on the day and did not attend the group.

Group support was evident as members affirmed and encouraged each other, it was obvious that they felt they could talk to each other when they felt sad or afraid. They all felt that it was still not ok to cry when they felt sad, however, “T”, “C” and “A” said they cried when they were angry. “Y” said she would “just kick things” when she feels angry. All members felt that they would have a bond even after the group meetings ended.

The “AIDS game” was played. It is a board game that explores common themes experienced by children who have lost someone close to them. This game provides an outlet to release the child’s feelings of anxiety, anger, and sadness. The following were issues that caused concern for this group of children:

- All of the children, except “M” who was not in the group, said that they knew about HIV and AIDS but not one group member knew of anyone who was sick, or had died from HIV or AIDS, confirming the “conspiracy of silence” attributed to this pandemic.
- All of the children had helped care for their sick parent, and had worried that they, or others close to them, may get sick and die.
- All of the children worried about being left alone.



Refreshments were shared and the leader outlined the next session asking the group members to bring something that reminded them of their parent which may be used in the next session. It was mentioned that if they did not have something to bring we would create something in the session.

#### 4.3.12.4 Session four - Worries that AIDS orphans have

The session began with each member reporting on how they were feeling and whether they had brought a special memento with them. "M" was back at school and feeling better.

Clay dough was used as a sensory stimulation exercise to enable the group to make something that reminded them of their parents. The clay was smelt and squashed, rolled and stretched. The children were then asked to make something with the clay that reminded them of their parents.

"A" made a coloured ball; she said her mum used to play with her, with a ball like the one she'd made. "Y" created a very colourful house; she said that she used to live in a house with mom and dad, but now she stays in a boarding house and misses her home so much. "M" created a robot man and told a story of how she and her mom had gone to visit the robot man. "M" found it very difficult to attend to a task given to her and often escaped into fantasy. This may be due to resistance, but is more likely due to other factors, including developmental challenges. "T" also made a ball; she used to play netball with her mum and really enjoyed and misses this interaction. "C" made a book, she appeared to feel very shy when talking about this book and just said she liked reading with her mom. The items were then placed in the memory box.

A breathing and meditation exercise, making use of colour, was used to introduce the worry tree. The group was asked to visualise themselves in a blue bubble floating in the sky. They were introduced to the worry tree which had a big star at the top. The children were told that the tree was waiting to take their worries away from them. They needed to visualise themselves hanging their worries on the tree.

After the meditation the group was asked to draw their worry tree and to hang their own worries on this tree.

“A”, usually reserved, entered into this exercise with great commitment. Her tree had a huge squirrel hole, which spanned the width of the trunk. This may indicate a need for nurturing, this was confirmed when she curled up and began to suck her thumb on completion of this exercise. “A” completed her drawing and then curled up in a foetal position and started to suck her thumb. In her drawing she placed herself in the tree and the following worries were hung on the outside of the tree:

- I will get in trouble
- My friends tease me
- My family
- My sister will die
- To fail my test
- To get lost
- To fail math
- My Gogo will die
- I will stay alone

“T” drew the worry tree and hung lots of worries on the tree but did not write what they were. She drew a picture of herself and her mom at the bottom of the page. Both people were very small and had no hands. This could indicate a feeling of helplessness, but was unconfirmed. However, she also lay down and began to suck her thumb, possibly due to observing “A” doing this.

“C” drew her worry tree using lots of colour. She drew oranges and wrote her comments in coloured bubbles. She also drew a star and wrote “I am a star to my family” in a bubble below. “C” lives in foster care and this appears to relate to her foster family. The following comments were written around the worry tree:

- I worry about my family
- I love myself

- I love my family too
- I worry about my mom
- I worry when I get lost
- I worry about when I fail my test
- I worry when I lost my money
- If my auntie died

“C” also curled up and sucked her thumb when she had completed her drawing. “C” is in foster care having had the additional trauma of being raped. She is extremely shy and displays high levels of anxiety when sharing her story.

“M” drew her tree in the upper half of the page; around the tree she drew a black pond. She worries when she sleeps at night and thinks of her mom. “M” drew lots of stars and attached herself to the tree. She said she worries about failing a test, as her granny will be so angry she “can not even go home”. Unfortunately, due to the fact that there appears to be some evidence of intellectual delay, this is a harsh reality. These factors add to “M’s” feeling of an already compromised self-esteem.

“Y”, drew a very strong trunk with a star and a heart in it. She drew herself attached to the top of the tree. The worries that she placed on the tree were:

- I am a worry in class
- I am worried when I get in trouble
- I think about my mom

As “A”, “C” and “T” had already curled into the foetal position and were all sucking their thumbs, the rest of the group was asked to do the same. We then discussed how the experience of being a baby again felt. All five children said that it was very nice and that they felt loved and were able to cry. They all said they could not cry as they would get in trouble for it but it is something they all want to be able to do, cry. It appeared that no one in the group felt loved and cared for.

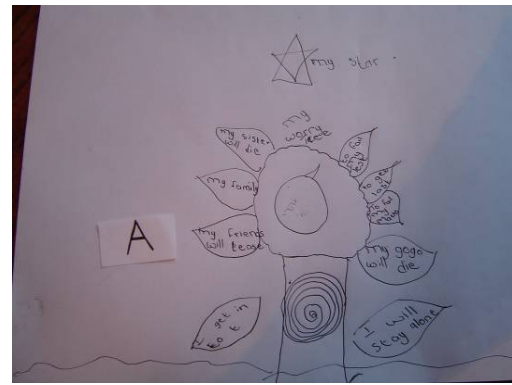
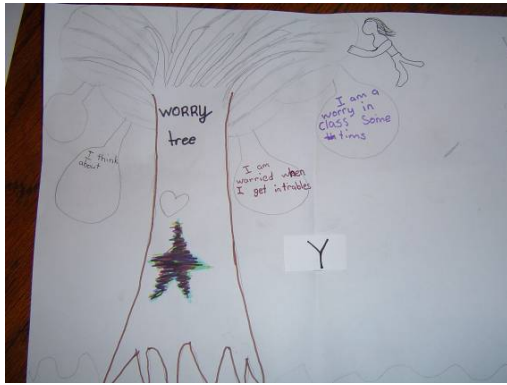
The discussion around the pictures of the worry trees then took place. The following common worries appeared to be of concern for all five members:

- They all worried that they or their caregiver would become sick and they would be left alone. This seemed to evoke a fear of being lost, and all five members feared getting lost.
- There was also the fear of not performing well at school. This fear was two fold; a fear of their guardians and a fear of their teachers. These children all indicated that they are so afraid to disappoint the people in their lives. It almost seemed that they have to prove their value.

The session ended with each child choosing a plastic animal, either domestic or wild, which had the qualities they needed to help them with their worries. These animals and the drawing of the worry tree were placed in the memory box to be explored at the next group.

Snacks were shared and the children were thanked for giving so much of themselves in this session. They all said that they felt happier and would put all their worries on the tree.





## Worry Trees

### 4.3.12.5 Session five - Writing a letter to the deceased parent

The session began with the leaders checking how everyone in the group was feeling. "M" indicated that her grandparents had been fighting over the weekend and that she had wanted to call the police. Her feelings of concern were normalised. All other members had had a good weekend with out worries.

The sensory awareness exercise was used to stimulate the awareness of taste. Each child was given a chocolate biscuit and asked to describe the taste and texture of both the biscuit and the filling. We also discussed our favourite biscuits and those which we did not like.

A discussion was then held on how the animal that each child had chosen at the previous session reflected who they are, and how these characteristics could help them in the situation in which they found themselves now.

“A” had selected the giraffe. She said it was because it could see far and was very quiet. It could also place the worries right on the top of the worry tree. She rocked back and forward throughout this discussion and said that, unlike the giraffe, she was not strong.

“T” had selected a horse. She said this was because it could run fast, is strong and can help with transport. She was once again distracted throughout this discussion.

“C” had selected a leopard. She said that this was because it could run fast and climb up trees when it was scared. “C” spoke very quietly and needed encouragement to contribute. She said that when someone wanted to hit her, the leopard would help her get away.

“M” had chosen an elephant. She said that this is because it is big and strong and you can ride on them. It can also get water and has big ears and can hear well. This was significant, given that “M” is very small in stature for her age. She also appears to be constantly in trouble at home and at school and has great difficulty attending to a task.

“Y” had chosen the dog. This is because it is a puppy and plays all day with his friends. The dog can also bark and protect. This was significant given that “Y” lives in a boarding house and has to fend for herself.

The group was again asked to talk about the purpose of these meetings. Some responses were:

- To talk about our mothers
- To remember our parents
- To talk about our feelings

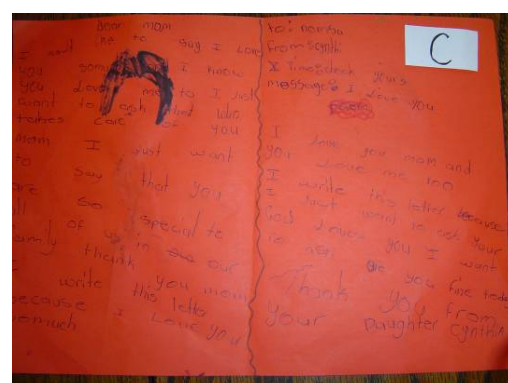
The children were then asked to write a letter to their parents. The leaders gave a few examples of the things that the children may want to ask. The children also added to the ideas. The children were encouraged to say what they needed to say and to explain to their parent how they have been doing since their death and possibly ask their parents what they were doing. This created a lot of excitement for the children and they all set about this task with great enthusiasm. "C" started writing and put a great deal of effort and concentration into this letter. "A" kept her letter well hidden and was anxious that someone would read it. "M" wrote her letter in another language, commenting that she was very tired. "T" just wanted to draw, but did, eventually write a short note eventually. "Y" set about the task with her usual precision and care.

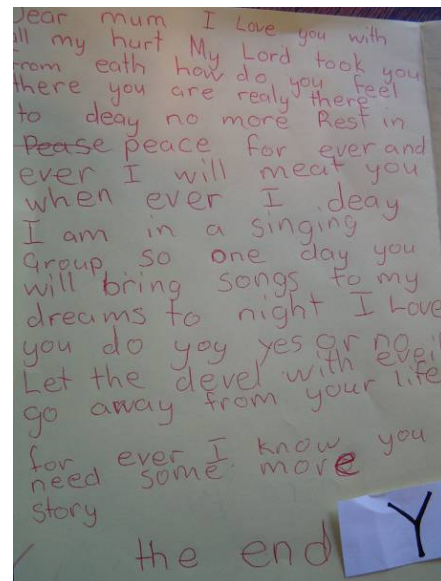
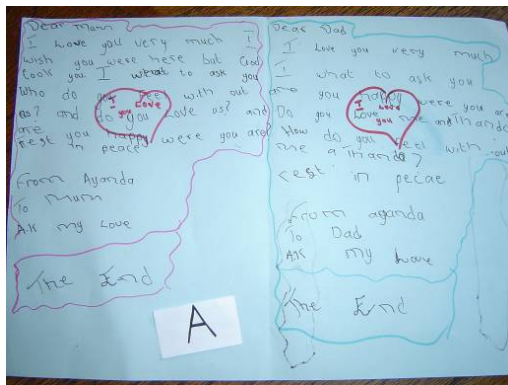
The group members were asked to share this experience with each other:

- They all felt that writing the letter had been a good, but sad, experience.
- They did not want to share the content of their letters.

Guided imagery was used to help the group to say goodbye to their parent. Some members of the group, "A" and "T", were sucking their thumbs and "M" was sucking her arm as they listened to the words. All members of the group reported that they had had a chance to say goodbye to their parents as they had all been ill for a long time before they died.

The letters to their parents were then placed in the memory boxes and a snack was shared.





## Letters to Parents

### 4.3.12.6 Session six - Goodbye

The group began with a discussion about how the members were and what they had liked and disliked about the group. They reported that they had enjoyed everything about the group sessions, but that it had been hard to talk and think about their parents. They said that it was good to talk about them, even if it made them feel sad.

A sprig of lavender bush had been placed on each memory box and the group was asked to smell the lavender. Most of the group did not like the smell, especially "A". The awareness of this plant was intended to trigger memories of this special group and the time shared together. All members were given a choice to throw the



lavender away or to place it in their memory boxes. They all elected to place it in their memory boxes.

The group members were then asked to draw a picture of themselves. Once completed, they were asked to write the qualities that made them who they are, around the picture. "M" had to be prompted, as she could not think of anything to write down. The others all had many positive attributes that they included, discussing it among themselves. These qualities were discussed and the group could add to one another's lists. This picture was placed in the memory boxes to be looked at often.

#### POST-TEST

The children were asked to complete the Piers Harris self-concept test as a post-test.

A group photo was taken which was placed in the boxes.

The members were then given the option to attach the letter that they had written to their parents to a helium filled balloon, or to write another one to attach to the balloons, keeping the original in their memory boxes. All elected to write another letter. These were attached to the balloons and the balloons were released from the school field. The children really enjoyed this exercise, and were shouting encouragement to their balloons to go faster.



“Posting” the letters”

We shared our last snack together and a beaded bracelet was given to each member of the group including the leaders so that we could have a reminder of our special time together. The children were given their boxes to take home.

#### **4.4 Analysis of the Data**

It was obvious from the first session that these children, who have experienced the death of their parents, become less anxious about their situation, by being exposed to group members who have suffered similar losses. This was evident by the surprise that the group member's voiced in discovering that they had all lost their parents. Group treatment for latency-age children from families inflicted with AIDS may legitimise their feelings of grief, stigma, shame and isolation, and further the healing. In this group however, the stigma is so strong that although all the children knew about HIV and AIDS not one of these children “knew” anyone who had died from this disease.

It was also evident that these children were not encouraged to talk about their parents and they all felt that they could not cry or show sadness about their loss, as this would annoy their caretakers. The memory box provided an opportunity for the group members to experience their feeling, and to have a tangible object on which to direct these feelings.

#### 4.4.1 Analysing the baseline data

<b>Pre-test T-Score on Piers-Harris children's self-concept scale</b>									
<b>Child</b>	<b>INC</b>	<b>RES</b>	<b>TOT</b>	<b>BEH</b>	<b>INT</b>	<b>PHY</b>	<b>FRE</b>	<b>POP</b>	<b>HAP</b>
"T"	70	54	44	43	54	42	41	39	36
"C"	65	69	43	49	44	52	41	44	37
"A"	43	40	45	54	46	42	43	50	51
"Y"	53	58	48	49	65	48	43	50	43
"M"	60	61	31	33	27	38	35	36	40

Table 4.1 Baseline data

##### 4.4.1.1 Validity considerations of the pre-test

INC: Inconsistency Responding. ( $T \geq 70$ ) may indicate random responses to some of the questions. "T" scored 70 and her scores were interpreted with caution. The other four scores were below 70, indicating that the responses were consistent.

RES: Response Bias. ( $T \geq 70$ ) or ( $T \leq 30$ ) may indicate a "yes" or "no" bias. All five scores were between 30 and 70 therefore the response bias was not observed in either direction.

TOT: Total Score. ( $T \geq 66$ ) may indicate "faking good". All five scores were below 66 which means that the children were not "faking good" and their scores were

accepted as a reliable measure of self-concept. "T", "C", "A" and "Y" scored in the average range and this indicated that they reported a level of self-esteem that is comparable to most of the children in the standardised sample. This usually indicates a balanced self-evaluation, with acknowledgment of both positive and negative aspects of the self. "M" scored in the low range, which indicated that she has serious doubts about her self-worth.

#### 4.4.1.2 Interpretation of the domain scales

- BEH: Behavioural Adjustment. "T", "C", "A" and "Y" scored within the average range, ( $T40 \geq T55$ ), this indicated that they evaluated themselves as fairly well behaved, but that they did acknowledge a few difficulties with their conduct. "M" scored in the low range, ( $\leq T39$ ), which indicated significant behavioural difficulties. It was evident that she often saw herself as being the cause of trouble.
- INT: Intellectual and School Status. "Y" scored in the above average range, ( $\geq T56$ ), this indicated confidence both in her general intellectual abilities and in her performance on specific academic tasks. "T", "C" and "A" scored in the average range, ( $T40 \geq T55$ ), which indicated that they felt that they were performing acceptably well in the academic field. They did however acknowledge a few difficulties with school related tasks. "M" scored in the low range, ( $\leq T39$ ), suggesting that she experienced numerous difficulties on specific school-related tasks.
- PHY: Physical Appearance and Attributes. "T", "C", "A" and "Y" scored within the average range, ( $T40 \geq T55$ ), they reported both positive and negative appraisal of their appearance and personal attributes, with positive evaluations tending to outnumber the negative ones. "M" scored in the low range, ( $\leq T39$ ), which indicated a poor self-esteem in relation to her body image and physical strength. She felt that she was unattractive and not well liked.
- FRE: Freedom from Anxiety. "T", "C", "A" and "Y" scored within the average range, ( $T40 \geq T55$ ), this indicated that they report mostly positive emotional

states, but that they acknowledge a few difficulties related to their moods. All four girls scored below T44 reflecting that they admit to experiencing more unpleasant emotions than the typical individual. “M” scored in the low range, ( $\leq$  T39), acknowledging significant problems with dysphoric moods indicating a generalised sense of anxiety.

- POP: Popularity, represented the child’s evaluation of her social functioning. “C”, “A” and “Y” scored within the average range, ( $T40 \geq T55$ ), this indicated that they are mostly satisfied with their social functioning but they did nevertheless acknowledge a few difficulties with their peer interaction. “T” and “M” scored in the low range, ( $\leq$  T39), which indicated that they feel unhappy about their social functioning. They felt dissatisfied with their friendships and felt that they do not have close friends and felt isolated.
- HAP: Happiness and Satisfaction reflected feelings of happiness and satisfaction with life. “C”, “A” and “Y” scored within the average range, ( $T40 \geq T55$ ), which indicated both positive and negative appraisals of their general life circumstances, with positive evaluations tending to out number the negatives. “T” and “M” scored in the low range, ( $\leq$  T39), which indicated a general unhappiness and dissatisfaction with themselves.

Once the pre-test was completed the children were asked if they knew why they were in the group. They were not sure. The leader then stated that everyone in this group had experienced the death of their parents and that the intention of the group was to help each other. The boxes were distributed. The idea of a memory box was explained to the children and they decorated then as they wished.

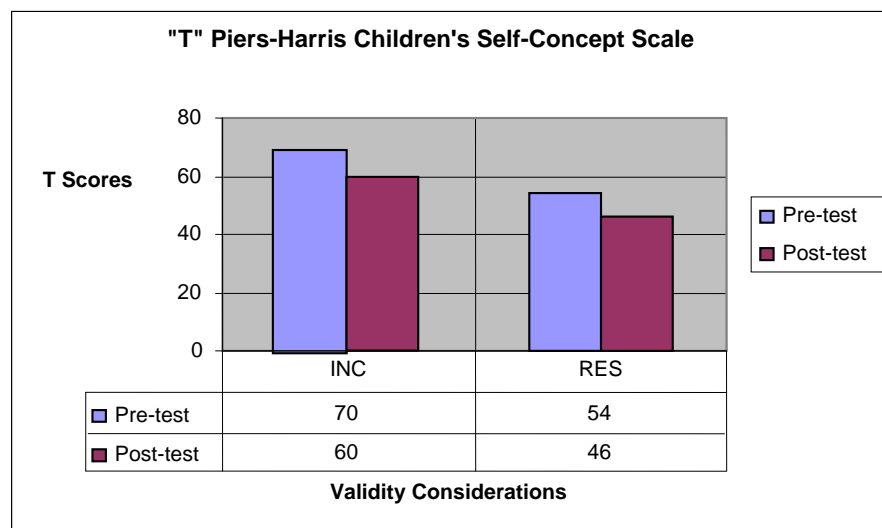
#### 4.4.2 Data-analysis of intervention data

“T” is a girl aged eight years and one month. Her mother passed away two years ago and she now lives with her grandmother. She has an older sister with whom she has contact. “T” was an active member of the group who loved to dance in front of the mirror which was situated in the therapy room. She presented with contact

boundary disturbances, indicating that she has great difficulty dealing with her situation. She would often break contact through dance and frequent visits to the bathroom.

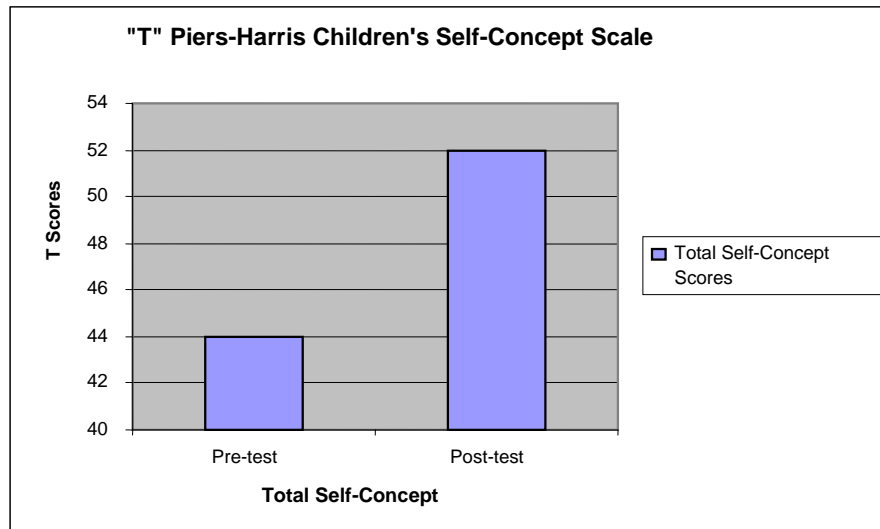
A comparison between “T’s” pre-test and post-test scores, on the Piers-Harris children’s self-concept scale, indicated that her awareness of self had increased on many fronts.

Figure 4.1 demonstrates that the inconsistency level of “T’s” post-test was decreased by 1 standard deviation. The response bias had also decreased substantially. This may indicate a greater awareness and concentration during the post-test.



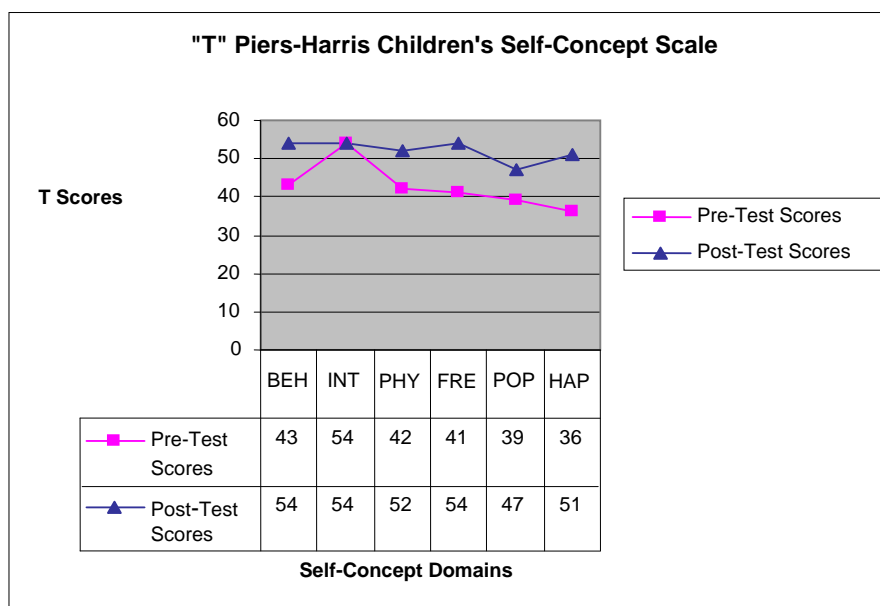
**Figure 4.1: Validity Considerations of “T’s” scores**

The graph in Figure 4.2 represents the total self-concept score, on the Piers-Harris children’s self-concept scale. There was a substantial increase in “T’s” total self-concept, (diff=8T), indicating that “T” evaluated herself in a more positive way after taking part in the group sessions.



**Figure 4.2: Total self-concept scores for "T"**

The graph in Figure 4.3 illustrates the six domains measured by the Piers-Harris children's self-concept scale. "T" scores higher in every domain except for intellectual and school status, which remained unchanged:



**Figure 4.3: Six domains measured by the Piers-Harris Self-Concept Scale for "T"**

- "T" now perceives herself as fairly well behaved. She scored higher on the post-test (54T), when compared with her scored on the pre-test (43T). The difference of (diff=11T) is due to the fact that she now perceives herself as good at schoolwork, a good person and she no longer feels that her grandparents expect

too much of her. This may be due to the group experience of being a valued member of the group and an acknowledgement and facilitation of her need to break contact. The process of making a memory box may also have added to a feeling of containment.

- “T’s” score regarding intellectual and scholastic status remained the same (54T). “T” is confident about her general abilities. She now feels that even though she is good in schoolwork she can be “dumb” at times. This may indicate awareness that it is ok to be “dumb” sometimes. As can be seen in Chapter two, this stage of development involves the transition to logical thought.
- “T” positively evaluated herself on physical appearance and attributes. She scored higher, (diff=10T), on the post-test. Increased awareness and positive feedback from the group may have lead to this increase. “T” indicated that her looks no longer bother her and that she thinks she has a pleasant face. This change was also reflected in the self-esteem exercise.
- “T” scored significantly higher on the post-test, (diff=13T), than the pre-test for freedom from anxiety. She now reports mostly positive emotional states. This may be due to the fact that she no longer feels shy, and experienced the group as a supportive and accepting environment where she could identify with other members through their sharing of emotions. She felt that it was still not acceptable to cry. It is interesting to note that not being allowed to cry was the reason that all members expressed enjoyment of pretending to be a baby again.
- “T” scored higher on the popularity scale, (diff=8T), she no longer sees herself as a shy person and does not see herself as being chosen last for games and sport. Most significantly, she no longer sees herself as being different from other people. During the middle childhood development phase it is important for children to feel accepted and safe within their peer group. “T” became aware of herself, her likes and dislikes, and this awareness may have contributed to her positive evaluation of her social functioning.
- “T” scored significantly higher on the post-test of happiness and satisfaction, (diff=15T), indicating that although she evaluated her life both positively and negatively, the positive evaluations tended to outnumber the negative ones. These changes can be observed in the fact that “T” no longer wishes she were different. She is able to acknowledge that although she is not unhappy she is

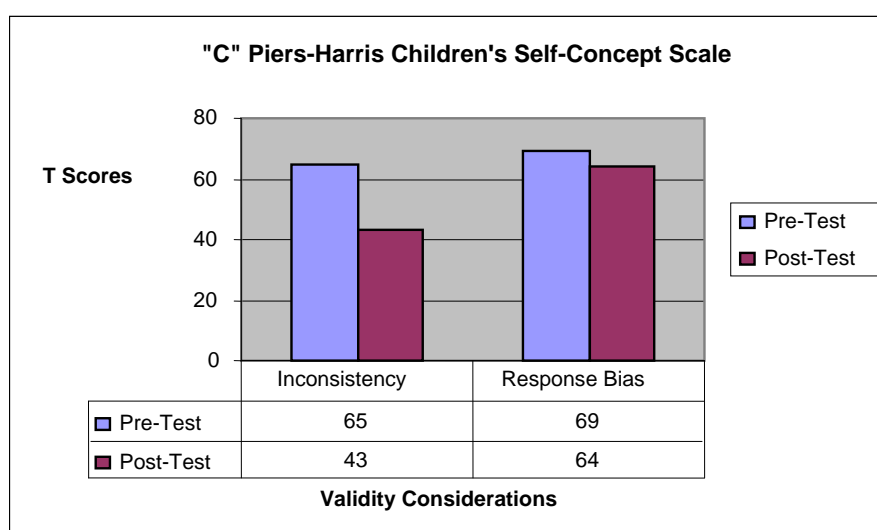


also not always cheerful. She sees herself as having a pleasant face and as being easy to get along with. She now also sees herself as a good person.

“C” is a girl aged seven years and ten months. Her mother passed away two years ago and she now lives in foster care as she has been sexually abused. “C” is shy and certainly the quietest member of the group, who found it extremely difficult to discuss herself and her feelings in the group. She presented with contact boundary disturbances possibly due to the additional trauma of the sexual abuse. Although she attended to every exercise with great effort, she was reluctant to discuss her “stuff”.

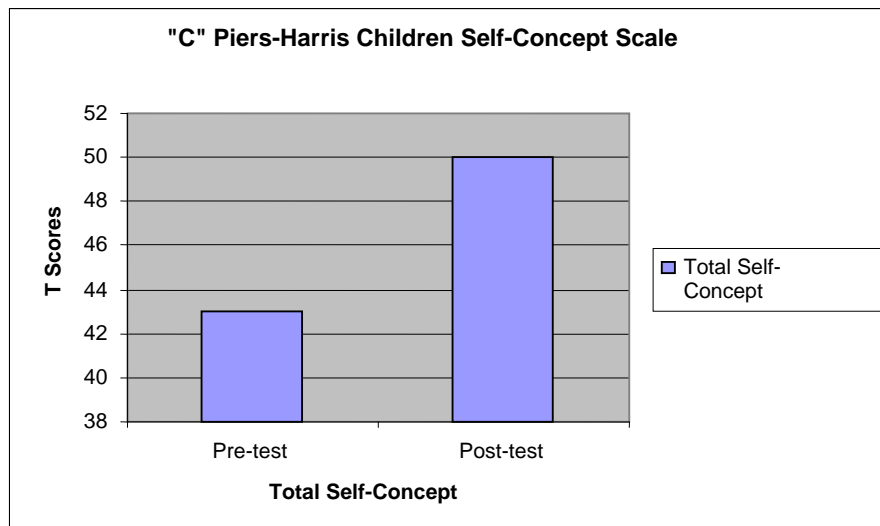
A comparison between “C’s” pre-test and post-test scores, on the Piers-Harris children’s self-concept scale, indicated that her awareness of self had changed on many fronts:

The graph in Figure 4.4 demonstrates that the inconsistency level of “C’s” post-test had decreased by  $\geq 2$  standard deviations. The response bias had also decreased substantially. This may indicate a greater awareness and possibly less anxiety during the post-test.



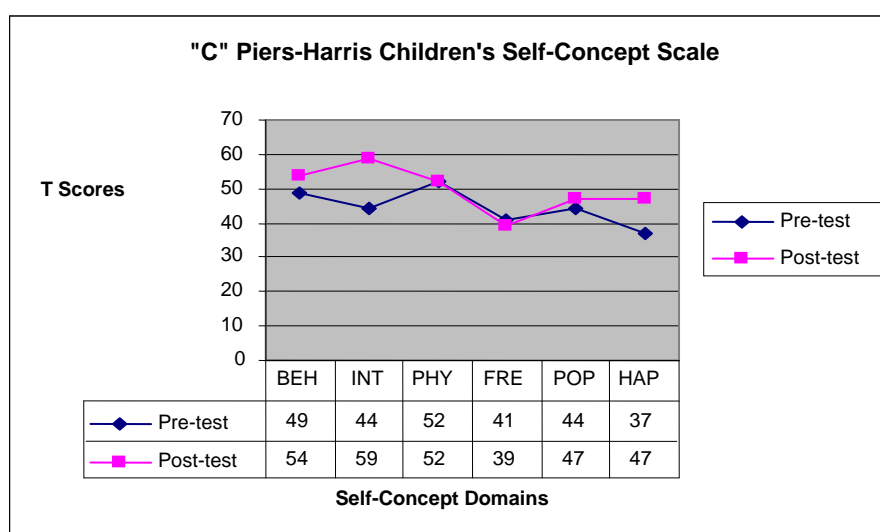
**Figure 4.4: Validity considerations of the Piers-Harris Self-Concept Scale for “C”**

The graph in Figure 4.5 represents the total self-concept score, on the Piers-Harris Children's Self-Concept Scale. There was a substantial increase, (diff=7T), in "C's" total self-concept, indicating that "C" evaluated herself in a more positive way after taking part in the group sessions.



**Figure 4.5: Total self-concept score for "C"**

Figure 4.6 illustrates the six domains measured by the Piers-Harris children's self-concept scale. "C" scores higher in every domain except for physical appearance and attributes, which remained unchanged and freedom from anxiety, which had decreased slightly:



**Figure 4.6: Six domains as measured by the Piers-Harris Self-Concept Scale for "C"**

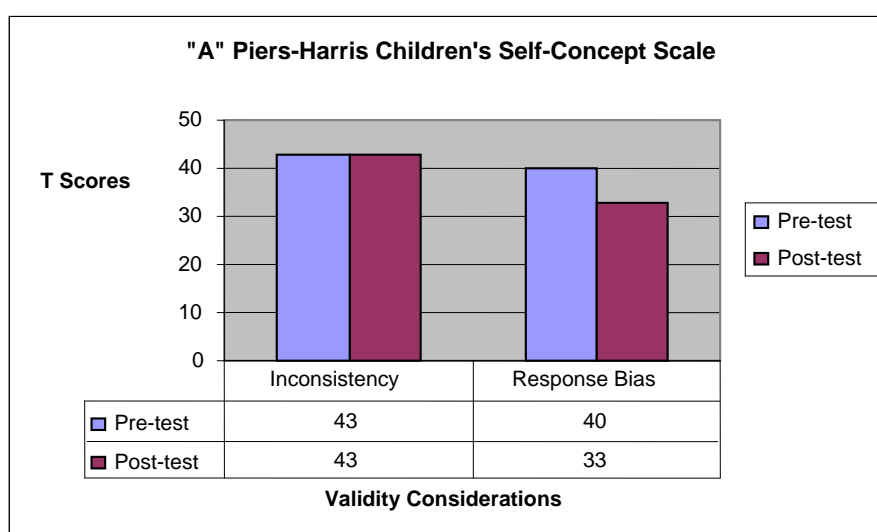
- “C” evaluated herself as being fairly well behaved, there was a slight increase, (diff=5T), on the post-test. “C” feels that her foster mother expects too much from her, and that she is unkind to other people sometimes. She was very quiet in the group, but put an enormous amount of effort into each project. It appeared that she really wanted to please the facilitators. She responded positively to the encouragement and increased self-awareness.
- “C” scored significantly higher, (diff=15T), on the post-test of intellectual and scholastic status, she sees herself as extremely confident in her general abilities and competent with specific tasks. She sees herself as smart, even though she may be slow at finishing her work. She no longer sees herself as a dreamer in class, possibly due to increased participation throughout the group sessions. She does not evaluate herself as “dumb” nor does she forget what she has learned. “C” experienced a feeling of belonging in this group, and became aware of her own process, which could account for her increased feeling of success and her own positive evaluation of her intellectual and scholastic status.
- “C’s” score on the physical appearance and attributes domain remained unchanged. She feels smart but at times her looks bother her. It should be noted that this may also relate to the effects on her body image due to the sexual abuse.
- “C” appears to be more aware of her true feelings and her score for freedom from anxiety dropped slightly, (diff=2T), however, this may indicate that “C” acknowledges her problems with anxiety. This may be due to a more realistic appraisal of her situation. Although she reported that she no longer feels sad and unhappy, she has become aware that she is shy and that she does worry a lot. This awareness creates a forum for her to address the actual issues.
- “C” evaluated herself as slightly more popular. Her score increased (diff=3T), indicating that although she feels shy, she no longer feels picked on or left out. “C” was a valued member of the group and responded well to the encouragement that she received from all members of the group. It appears however, that she still finds social interaction difficult.
- “C” scored significantly higher on the happiness and satisfaction scale (diff=10T). She no longer reported general unhappiness and dissatisfaction with herself. Through the group interaction and acceptance, and the heightened awareness

of herself, she no longer feels unhappy and even sees herself as cheerful. She evaluated herself as easy to get along with. This feeling of acceptance by the peer group is vital for the child in middle childhood, especially when they have been orphaned and peers and teachers become their security. Putting the memory box together could also contributed to her feeling of wellbeing as she was able to tell her story, and place her treasures in the box.

“A” is a girl aged nine years and one month. Her mother passed away three years ago and her father passed away last year. She lives with her maternal grandparents. “A” was the oldest member of the group. She found it extremely difficult to acknowledge and discuss her feelings in the group. She presented with contact boundary disturbances, on many occasions sucking her thumb and often curling into the foetal position while sucking her thumb. Cognisance of this occurrence was taken, and her awareness drawn to this self-nurturing behaviour. “A” responded to her feelings in a visible manner, she would often look pale or rock backwards and forward.

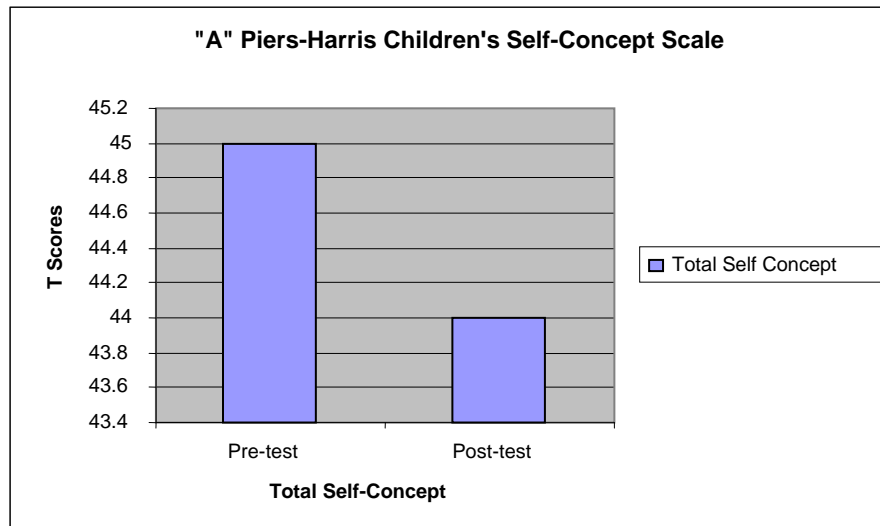
A comparison between “A’s” pre-test and post-test scores, on the Piers-Harris children’s self-concept scale, indicated that her awareness of self had changed on many fronts.

Figure 4.7 demonstrates that the inconsistency level of “A’s” post-test was the same as her pre-test. The response bias had also decreased slightly, (diff=7T).



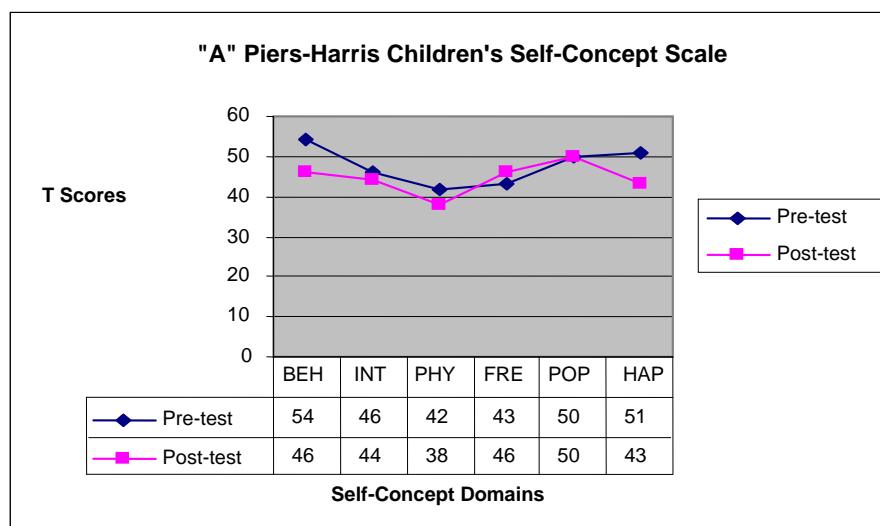
**Figure 4.7: Validity considerations of the Piers-Harris Self-Concept Scale for “A”**

Figure 4.8 represents “A’s” total self-concept score on the Piers-Harris children’s self-concept scale. There was a slight decrease in “A’s” post-test, (diff=1T), when compared to her pre-test. This indicated that on the whole “A” evaluated herself in a slightly more negative way after taking part in the group sessions.



**Figure 4.8: Total self-concept scores for “A”**

The graph in figure 4.9 illustrates the six domains measured by the Piers-Harris Children’s Self-Concept Scale. “A”, scores lower in every domain except for popularity, which remained unchanged and freedom from anxiety which increased slightly:

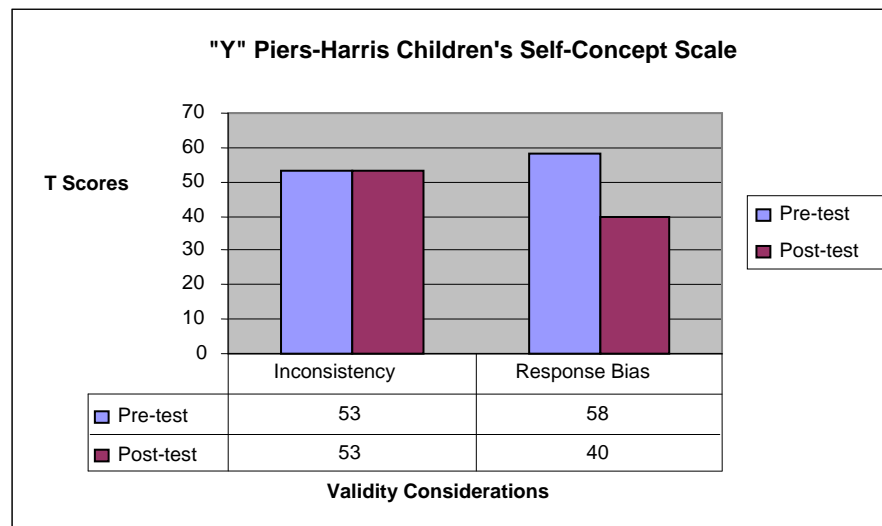


**Figure 4.9: Six domains as measured by the Piers-Harris Self-Concept Scale for “A”**

- “A” rated herself as having more behavioural difficulties after completion of the group sessions than on she did on the pre-test, (diff=8T). This may have been due to the awareness created surrounding her physical demonstration of her psychic pain. “A” also thinks bad thoughts, given that she has suffered a double loss in a short space of time, this may indicate that she still struggles with her pain. It may also indicate better contact-making and being more in touch with herself and the feelings hat she has tried to disguise.
- “A” admitted to having more difficulties with her academic work in her post-test than she did at the pre-test, (diff=2T). She felt that although she volunteered her help, her peers often did not like her ideas.
- “A’s” appraisal of her physical attributes, including leadership and ability to express ideas is very low in the post-test, (diff=4T). Although she sees herself as a leader in games and sport, she feels that her peers do not like her ideas. She also feels that her face is not pleasant, indicating self-criticism. This lower score may be attributed to her intense physical reactions, to emotional pain and an increased awareness of these feelings.
- “A” evaluated herself as having slightly more freedom from anxiety (diff=3T). She experiences less worry in general, and less worry surrounding school tests, however, she is now more aware of her unhappiness. It was during the exercise on worries that “A” first began to suck her thumb and curled into a foetal position. She expressed that it was nice to be a baby because she could cry. Although the test result indicate reduced anxiety, “A’s” environmental support appear to be lacking.
- “A’s” score on her social functioning remained unchanged. She now realises that she is not different to others although her circumstances may be. She is also aware that her peers do not always agree with her ideas, but that this is normal and her scores reflect this. It was interesting for “A” to note that other members of the group began to suck their thumbs as well.
- “A” admitted to feeling dissatisfied. Her score in the post-test was lower, (diff=8T), this could have been due to an increased awareness of her feelings. It was noted that “A” tried to disguise her feelings on many occasions, but her body could not maintain the “bluff”. This acceptance of her true feelings may foster better contact and need fulfilment.

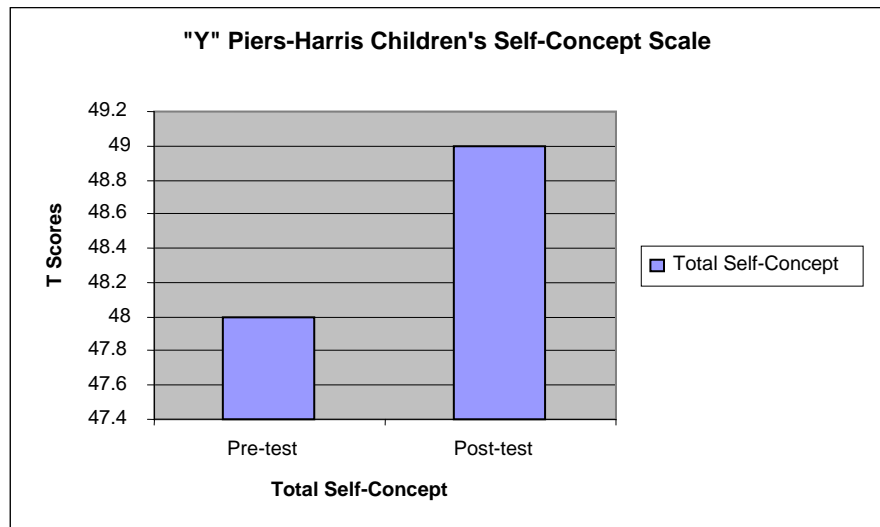
“Y” is a girl aged eight years five months. Her father passed away three years ago and her mother passed away two months ago. She lives in a boarding house, and it was clear that she had to take care of herself. “Y” has a brother who she sees on weekends, but he is unable to take responsibility for her. “Y” was without doubt the leader of the group. She found it extremely difficult to let others take the lead, but tried to when this was pointed out. “Y” appeared to be competent and well organised. This was of concern, given that she has very recently lost her mother and missed her kindness very much.

Figure 4.10 demonstrates that the inconsistency level of “Y’s” post-test was the same as her pre-test. The response bias had also decreased slightly, (diff=8T).



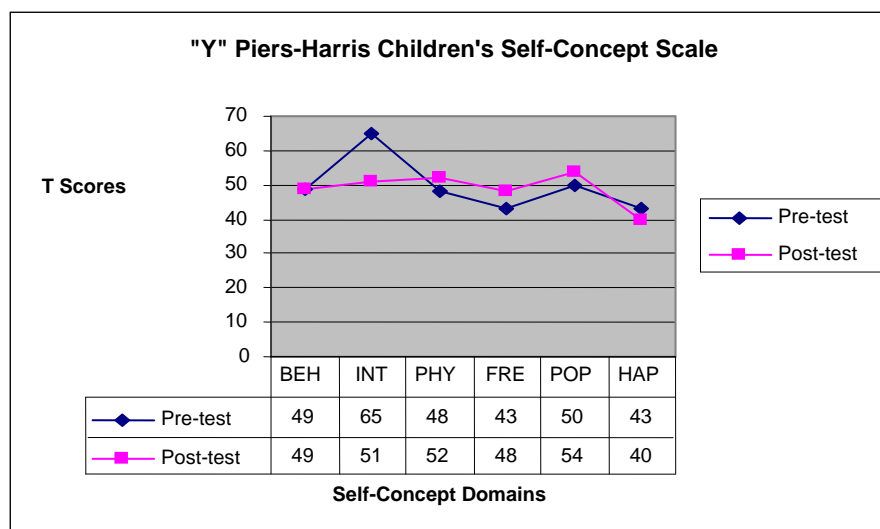
**Figure 4.10: Validity considerations of the Piers-Harris Self-Concept Scale for “Y”**

Figure 4.11 represents the total self-concept score, on the Piers-Harris children’s self-concept scale. There was a slight increase in “Y’s” post-test, (diff=1T), when compared with her pre-test. This indicated that on the while “Y” evaluated herself slightly more positively after taking part in the group sessions.



**Figure 4.11: Total self-concept scores for "Y"**

In Figure 4.12 the graph illustrates the six domains measured by the Piers-Harris children's self-concept scale. "Y", scores higher in every domain except for two. Her score for happiness and satisfaction, was decreased slightly, and for her score for intellectual and scholastic status, decreased substantially, possibly due to more realistic demands being made on herself.



**Figure 4.12: Six domains as measured by the Piers-Harris Self-Concept Scale for "Y"**

- "Y's" score on the behavioural adjustment scale remained the same. However she is now however able to admit to herself that she does not always behave well at school, she can also acknowledge that she can be mean to other children at

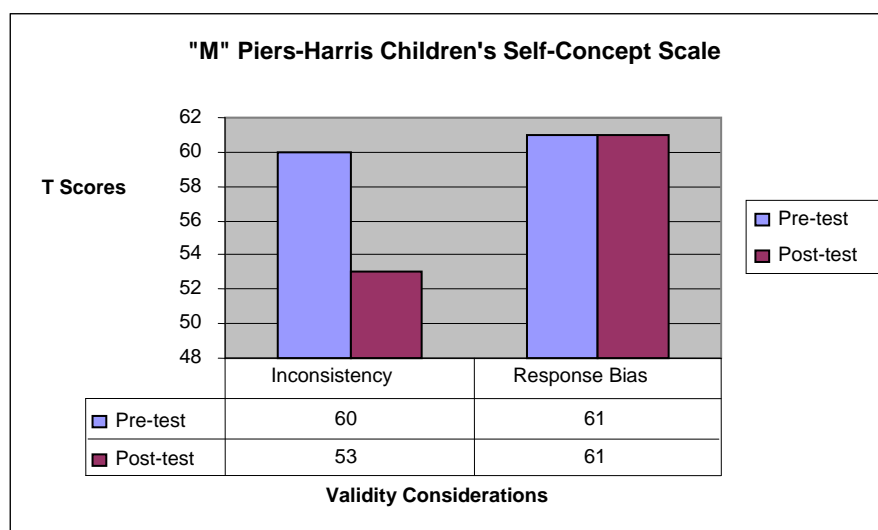


times. The realisation that she does not have to be “perfect” must have been liberating for her. “Y” has so many responsibilities pertaining to herself for someone so young.

- “Y” admitted to having significantly more difficulties with her academic work than during the pre-test, (diff=14T), this may have been due to a more realistic view of herself. She felt that although she did not always behave impeccably in class, and at times her peers did not value her, she did not have to make them. The drop in score therefore may be due to an increased awareness that it's acceptable to be just who she is.
- “Y's” appraisal of her physical attributes, including leadership and ability to express ideas, increased slightly in the post-test, (diff=4T). Although she sees herself as a strong person she feels that does not look good enough, which may indicate self-criticism and high ideals.
- “Y” evaluated herself as having slightly more freedom from anxiety, (diff=5T). Although “Y” wished she were different and felt discontented with her looks, she experienced herself as having less nervousness and found that she also worried less after the sessions. This may have been due to the awareness that even though she has to take care of herself, she is still a child with childlike needs.
- “Y's” evaluated her social functioning as having improved slightly, (diff=4T). She now possibly realises that she can, and does, interact with her peers more than she allowed herself to believe. “Y” was a very popular member of the group, with other members letting her take the lead and looking to her for reassurance.
- “Y” admitted to still feeling dissatisfied, her score for satisfaction in the post-test was lower than in the pre-test, (diff=3T), this lower score may have been due to an increased awareness of her feelings and her situation. It was noted that “Y” lived in a boarding house, where she had a bed. She is fed at the school and has no one at home to care for her. She copes through being organised and the organiser. A realistic awareness of her situation could allow her to identify key players in her environment who can nurture her and ensure that she is able to concentrate on the developmental tasks of a child in the middle childhood phase of development.

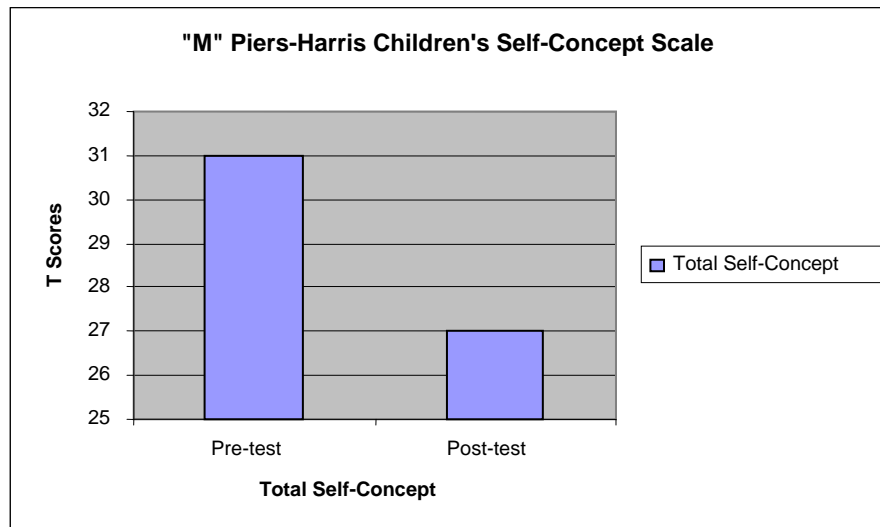
“M” is a girl aged eight years eleven months. Her mother and father both passed away during the same month, seven months ago. She lives with her grandmother, who appears to be very harsh on “M”. “M” was the clown of the group. She found it extremely difficult to concentrate and her very poor sense of self resulted in poor contact-making. “M”, broke contact almost every time she needed to become aware of her situation. She continually complained of being very tired, and had countless bathroom trips each session. “M” often said she did not want to talk about her parents she “just wants to forget.” “M” is unable to express her sadness and is harshly punished for any transgressions.

Figure 4.13 demonstrates that the inconsistency level of “M’s” post-test was reduced when compared with her pre-test, (diff=8T). The response bias was unchanged. This difference could be attributed to the fact that “M” was slightly more in contact with herself by the end of the sessions.



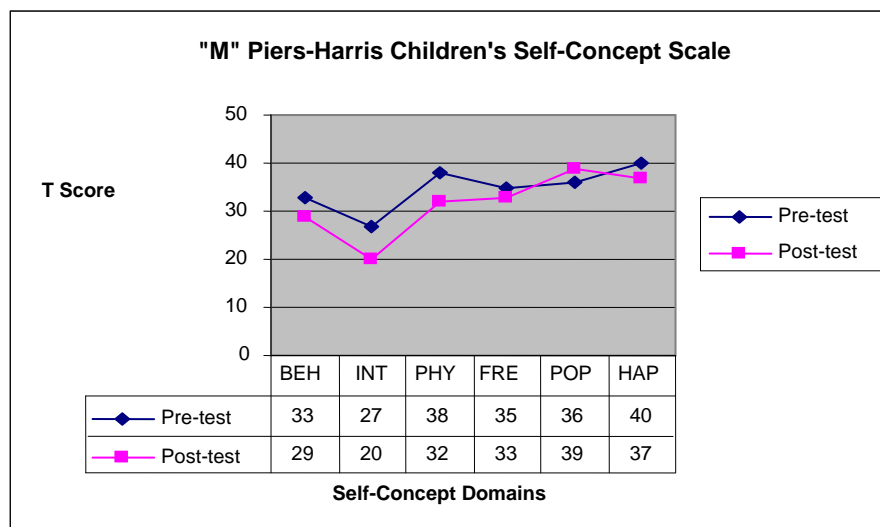
**Figure 4.13: Validity considerations of the Piers-Harris Self-Concept Scale for “M”**

Figure 4.14 indicates a comparison between “M’s” pre-test and post-test scores, on the Piers-Harris children’s self-concept scale, indicated that her overall self-concept had dropped, (diff=4T). This may be due to her increased awareness of her situation, after taking part in the group sessions, given that her coping method is escapism.



**Figure 4.14: Total self-concept scores for "M"**

The graph in Figure 4.15 illustrates the six domains measured by the Piers-Harris children's self-concept scale. "M", scores lower in every domain except for popularity, which increased slightly possibly due to the acceptance and value she enjoyed in the group:



**Figure 4.15: Six domains as measured by the Piers-Harris Self-Concept Scale for "M"**

- "M" score even lower than her already low pre-test, (diff=4T), on the behavioural attributes scale. She sees herself as causing trouble for her grandparents, as she is often in trouble. "M" feels it is usually her fault when things go wrong,

although she no longer does “bad things”. “M” appears to get in fights often, but does not think that she is mean to others.

- “M” again scored significantly low on the intellectual and scholastic scale, (diff=7T). Her score of  $\leq 20T$  is alarmingly low and may indicate an incorrect school placement. Although she no longer sees herself as “dumb” about most things, she does not think she will be an important person when she grows up. This is reflected in her low self-concept. “M” found it extremely difficult to concentrate and would often have to go out of the room. The decrease in her score may however indicate an increased awareness of her problems.
- “M’s” appraisal of her physical appearance and attributes was increasingly negative, (diff=6T). She does not acknowledge that she may be pretty or cute despite the group continually telling her as much.
- “M” scored slightly lower on the post-test regarding freedom from anxiety, (diff=2T). “M” feels that she gives up easily, but no longer feels so nervous. “M” found the sensory stimulation interesting but frequently could not complete the exercise.
- “M” perceived her social functioning as slightly improved after the last group session, (diff=3T). She no longer sees herself as different to other people. This could be due to the awareness she now has that she is not the only child who has no parents.
- “M” scored lower on the happiness and satisfaction scale (diff=3T). “M” feels that she is not lucky and wishes she were different. She feels that she is difficult to get along with.

Each of “M’s” scores fell in the extremely low range, it may be that she is simply not coping with her emotions and school and it appears that the grandmother is severely punitive, showing little understanding of “M”.

#### 4.4.3 Post intervention status of participants

Post-test T-Score on Piers-Harris children's self-concept scale									
Child	INC	RES	TOT	BEH	INT	PHY	FRE	POP	HAP
"T"	60	46	52	54	54	52	54	47	51
"C"	43	64	50	54	59	52	39	47	47
"A"	43	33	44	46	44	38	46	50	43
"Y"	53	40	49	49	51	52	48	54	40
"M"	53	61	27	29	20	32	33	39	37

Table 4.2: Post intervention status of participants

##### 4.4.3.1 Validity considerations of the post-test

INC: Inconsistency Responding. ( $T \geq 70$ ) may indicate random responses to some of the questions. All five respondents scored below 70 indicating that random response patterns were not detected.

RES: Response Bias. ( $T \geq 70$ ) or ( $T \leq 30$ ) may indicate a "yes" or "no" bias. All five scores were between 30 and 70 therefore no response bias in either direction was observed.

TOT: Total Score. ( $T \geq 66$ ) may indicate "faking good". All five scores were below 66 which means that the children were not "faking good" and their scores can be accepted as a reliable measure of self-concept. "T", "C", "A" and "Y" scored in the average range and this indicates that they report a level of self-esteem that is similar to that of most of the children in the standardised sample. This usually indicates a balanced self-evaluation, with acknowledgment of both positive and negative aspects of the self. "M" scored in the low range, indicating that she has serious doubts about her self-worth.

#### 4.4.3.2 Interpretation of the domain scales

- BEH: Behavioural Adjustment. “T”, “C”, “A” and “Y” scored within the average range, ( $T40 \geq T55$ ), indicating that they evaluate themselves as fairly well behaved but do acknowledge a few difficulties with their conduct. “M” scored in the low range, ( $\leq T39$ ), indicating significant behavioural difficulties. She still sees herself as being the cause of most of the trouble she finds herself in.
- INT: Intellectual and School Status. “Y”, “T”, “C” and “A” scored in the average range, ( $T40 \geq T55$ ), indicating that they feel they are performing acceptably well in the academic field. They do however acknowledge a few difficulties with school related tasks. “Y’s” score has dropped from the pre-test, possibly indicating a more realistic assessment of herself. “M” scored in the low range, ( $\leq T39$ ), suggesting that she experiences numerous difficulties with school-related tasks.
- PHY: Physical Appearance and Attributes. “T”, “C”, and “Y” scored within the average range, ( $T40 \geq T55$ ), thus reporting both positive and negative appraisal of their appearance and personal attributes, with positive evaluations tending to outnumber the negative ones. “A” scored lower on the post-test, possibly due to the awareness created. Her reactions were always intensely physical. “M” scored in the low range, ( $\leq T39$ ), indicating a poor self-esteem in relation to her body image and physical strength. She continues to feel that she is unattractive and not well liked.
- FRE: Freedom from Anxiety. “T”, “A” and “Y” scored within the average range, ( $T40 \geq T55$ ), indicating that they report mostly positive emotional states, but acknowledge a few difficulties related to their moods. The scores for these three girls increased above T44 reflecting that they experience mostly positive emotional states. “M” and “C” scores were both in the low range, ( $\leq T39$ ), acknowledging significant problems with dysphoric moods, indicating a generalized sense of anxiety, possibly due to a feeling of incompetence and always being in trouble.

- POP: Popularity represents the child's evaluation of her social functioning. "C", "A", "T" and "Y" scored within the average range, ( $T40 \geq T55$ ), indicating that they are mostly satisfied with their social functioning, but nevertheless acknowledge a few difficulties with their peer interaction. "T" scored significantly higher in the post-test, possibly indicating a feeling of acceptance and belonging in the group. "M" scored ( $\leq T39$ ), just within the low range, indicating that she still feels unhappy about her social functioning. It should be noted however, that this poses a significant increase from her pre-test score of T36. This may indicate that she felt accepted within the group.
- HAP: Happiness and Satisfaction reflects feelings of happiness and satisfaction with life. "C", "A", "T" and "Y" scored within the average range, ( $T40 \geq T55$ ), indicating both positive and negative appraisals of their general life circumstances, with the positive evaluations tending to outnumber the negatives. "M" scored in the low range, ( $\leq T39$ ), still indicating a general unhappiness and dissatisfaction with herself.

#### 4.4.4 Trustworthiness

Reliability concerns the stability of the scores on a psychological test. A reliable test should produce consistent scores for the same individual when she takes the test on different occasions or under different conditions of examination. A reliable test should also yield a score that is relatively free of measurement error or variance due to chance factors, rather than true variance in the psychological construct being assessed.

Internal consistency refers to how well the test items sample the content domain being assessed. In an internally consistent test, items tend to be highly inter-correlated, presumably because they are measuring the same construct. The Piers Harris 2 standardization studies, including Piers (1984) and Hattie (1992), using coefficient alpha, demonstrate that this measure has excellent internal stability (Piers & Herzberg, 2005: 50).

Test-retest reliability measures the extent to which scores for a single individual are consistent over time and across settings. Due to the fact that young children's sense of self is still developing, the test-retest reliability is low in comparison to that of older children. In general the shorter the test-retest interval, the higher the reliability estimates, making this measurement suitable for measuring the effectiveness of Gestalt group therapy using the memory box as a medium, with AIDS orphans in the middle childhood phase of development. Hattie, Metcalf, Piers & Harris, amongst others (in Piers & Herzberg, 2005: 51) reported a test re-test study for the Piers-Harris total score and six cluster scores indicating stability over time.

#### 4.4.5 Credibility

Validity refers to a test's ability to measure accurately those psychological characteristics that it purports to measure. Validity is a multidimensional concept that can be divided into several types, each of which plays a different role in establishing the usefulness and accuracy of the test. Content validity addresses the question of whether the test's item content adequately samples the behaviour that is being measured. A second type of validity, construct validity, refers to how well the test performs in measuring a psychological characteristic. Finally criterion validity evaluates how well the test performs in predicting an individual's performance in other activities (Piers & Herzberg, 2005: 52).

- Content validity: The Piers-Harris 2 exploratory factor analysis yielded a six-factor solution that supports the assignment of items to six domain scales designed to measure separate but interrelated aspects of self-concept. Content validity is supported by studies, including Piers in 1963 and Jersild in 1952, showing that these categories reflect the child's self-concept (Piers & Herzberg, 2005: 53).
- Construct validity: The Piers-Harris 2 standardization study provides two kinds of evidence related to construct validity of the Piers-Harris 2 instrument. Structural characteristics were assessed using both inter-scale correlation analysis and factor analysis. Findings support the notion that the domain scales represent separate, but inter-related aspects of self-concept. Convergent validity refers to the strength of correlation between Piers-Harris and measures of theoretically



similar constructs. This measuring instrument shows expected relationship with self-concept questionnaires as well as other personality and behavioural characteristics measures, including an expected negative relationship with SRA junior Inventory, Big Problems Scale, Children's Manifest Anxiety Scale (Piers & Herzberg, 2005: 63).

- Criterion validity of the Piers-Harris 2 indicates that it can differentiate between groups that would be expected to differ in self-concept. Research by Kinard, 1980 found that even in cases where the total score was not significantly different between groups individual responses indicated that abused children were more likely to respond in the direction indicating a negative self-concept (Piers & Herzberg, 2005: 69). Research by Pandina & Schuel, Guiton & Zachary and Kashani (in Piers & Herzberg, 2005: 69), add strength to the criterion validity of this scale.

#### 4.4.6 Ethical considerations

The guardians of all members of the group were contacted and consent forms were signed, giving permission for the children to take part in the Gestalt group therapy sessions. Although it was ascertained from the guardians that all the children in the group were orphaned by the AIDS pandemic, the children did not volunteer this information, in fact they denied it emphatically. This ethical consideration led to the AIDS issues being addressed indirectly, thus continuing the "conspiracy of silence".

### 4.5 Findings and Summary

This chapter outlined the research methodology and presented the empirical data gathered during the research process. This discussion of ascertaining and evaluating post-intervention, deals with the last objective for the study namely:

To capture post-treatment functioning in order to ascertain whether the memory box, as a medium for telling one's story in Gestalt group play therapy with AIDS orphans, had any positive results.

The conspiracy of silence surrounding HIV and AIDS is very much a part of life for these children.

Group therapy is an effective means of therapy when dealing with orphaned children. The memory box as a medium, worked very well in the group situation, as it offered an alternative to narrative therapy, which is more age appropriate.

In Chapter five the research report will be concluded with recommendations and conclusions on the research process.

# CHAPTER FIVE

## CONCLUSIONS AND RECOMMENDATIONS

### 5.1 Introduction

This study illustrated the utilisation of the memory box as a medium in Gestalt group play therapy with AIDS orphans in middle childhood.

To conclude the research a summary of the aim and objectives will be reviewed and the hypothesis accepted or rejected.

#### 5.1.1 Aim and objectives of the study

The aim of research is to expand knowledge, to explore and gather information on a topic. The aim of this research was to explore and describe the utilisation of the memory box as a medium for telling one's story in Gestalt group play therapy, with AIDS orphans in the middle childhood phase of development. This research report gave an in-depth review on all aspects of this aim and expanded on current knowledge by demonstrating through empirical results, the effects of utilising the memory box.

The objectives of a study realistically and within a time span, give structure to the “dream” of the aim.

The objectives of this study were:

- To explore and describe the Gestalt play therapy with AIDS orphans in middle childhood.
- To capture the respondent's baseline data with the use of a self concept scale as a measurement for change after Gestalt therapeutic intervention.
- To identify the respondent's responses towards the utilisation of the memory box.

- To capture post-treatment functioning in order to ascertain whether the memory box, as a medium for telling one's story was therapeutic in the group forum.

## 5.2 Conclusions

The study conclusively found that the use of the memory box in Gestalt group therapy with orphaned children in the middle childhood phase of development was cost effective and an enjoyable means of therapy. The stigma surrounding HIV/AIDS was also confirmed, and the group continued as a bereavement group without the focus being on AIDS.

The Single-System Design was an effective method of enquiry and the Piers-Harris an excellent measure of self-concept. In addition, the observation of each child within the group sessions served to confirm the findings.

In Chapter two the developmental tasks relevant to a child in the middle childhood phase of development were considered. These tasks were considered from various theoretical viewpoints, and the implications for the AIDS orphan were discussed. In this study physical, intellectual, emotional, social and moral development were discussed with special reference to how they impact on the self-concept of the AIDS orphan in the middle childhood phase of development. While comment cannot be made regarding AIDS orphans, as the orphans in this study did not, at any stage, consider that they may be orphaned due to AIDS, the following can be said about orphans in general:

- The child's perceptions of her physical appearance and attributes were considered and found to be of value when assessing her of well-being. The children in this study, who thought that they were not physically attractive and able, scored lower on the measure of self-concept. It appeared that the children who have been placed with relatives or in institutional care felt that they were not valued or precious. This in turn was reflected in the way they saw themselves.
- The child's interpretation of her intellectual and school status was also found to mirror her self-concept. The children that felt they were not clever scored lower

on the measure of self-concept. Once again, the children in this study felt under pressure to please the people taking care of them, often creating additional stress and very high expectations for themselves.

- The emotional development of the child was considered by looking at happiness and satisfaction and the levels of freedom from anxiety that each child felt. This was found to be significant in gauging the child's self-concept - the belonging and acceptance that the children in this study felt in the group situation was evident in the measurement thereof. The fact that all participants felt that they could not cry when they missed their parents because the guardians would be annoyed, indicated that they had to be emotionally guarded at home.
- The social aspect of the developmental tasks was addressed by looking at the child's perception of her own popularity and behavioural adjustment. These characteristics impacted on the child's self-concept. All members in this study felt that they were more popular after the group experience. The peer support and sharing offered by the group had certainly impacted on each one.

In Chapter three the theoretical aspects of Gestalt therapy were discussed and were implemented in this study:

Each child was seen as a holistic being including her story of the past as placed in the memory box, but not forgetting her present circumstances.

- Although all the members of the group were in fact orphaned by AIDS, they did not bring this to the group and in fact denied knowing anyone who had died from AIDS. This confirmed the "conspiracy of silence" that is assumed to surround HIV and AIDS. This is very definitely evident in the lives of these children.

Gestalt group therapy is an effective means of therapy when dealing with orphaned children.

- It was found that the gentle awareness which heightened at each session, brought most of the children into contact with themselves and therefore in contact with their environment. For the most part they became more realistically aware of their situation and their self-worth.

- Therapeutic contact and full sensory awareness proved vital, and in most cases this was achieved in order for the children to make the memory boxes. The children had to find the courage and strength to create the material that they then placed in the boxes.

It was found that in many instances the children were observed to be in the phoney or phobic layers of neurosis. It is believed that on all levels there was movement into the implosive level, and it is hoped that the children will continue to live in awareness.

Contact boundary disturbances were frequently observed and the children made aware of how this affects them in their lives. All were able to establish good contact, however they all showed aspects of introjections, projection and confluence. Resistance was seen to be present on many occasions, and in one case, remained part of the participant's way of being in the group.

Unfinished business was addressed in the form of the letter to their parents, it was interesting to note that the children wanted to know if their parents remembered them and missed them. Nothing relating to their grief was noted.

The memory box as a medium, worked very well in the Gestalt group therapy situation, as it offered an alternative to regular narrative therapy, which was more age-appropriate.

### **5.3 Recommendations**

It is recommended that Gestalt group therapy be offered at primary schools in the form of an open group. In this way, each child would be able to access the support and therapeutic value of attending such a therapeutic group. Since the HIV and AIDS "conspiracy of silence" is clearly evident and still so strong it could be assumed that current AIDS education is ineffective. Perhaps in the forum of such a support group, over a long period of time, these issues will be addressed.

It is recommended that guardians of these young children are educated as to the emotional needs of young children. Often it is the grandmother who is left to take care of the child. Lack of emotional investment was clear, and care must be taken not to equate physical care with nurturing.

#### **5.4 The Hypothesis**

The hypothesis of this study:

*The making of memory boxes in Gestalt group play therapy sessions will empower the AIDS orphans, aged 7-10 years old, increasing their self-concept resulting in a restored sense of self.*

With the empirical results in mind the researcher believes there is enough empirical evidence to accept the above hypothesis

#### **5.5 Concluding Remarks**

When considering the pandemic proportion of the AIDS crisis in South Africa today, and the long-term effect of being orphaned, in a society already overburdened with orphans, one realises that something must be done to assist these children. Through the literature study, it was found that cognisance must be taken of the issues and developmental tasks that face children in this middle childhood phase of development. Through Gestalt group play therapy, using the memory box, it is possible to make a difference to these children's lives, enhancing their self-concept and increasing their resilience. This could be extended to include open groups where members come and go as they feel the need.

## CHAPTER SIX

### 6.1 Appendix

#### 6.1.1 Letter of consent



gauteng - inner city, soweto, Tembisa, Katorus and Sebokeng

11 August 2006

**GROUP THERAPY FOR ORPHANS**

Dear Guardian

Childline will be running a therapeutic group for orphaned girls between the ages of 8 and 10 years old. The groups will be held at Johannesburg Girls Prep School on Monday and Friday mornings, during school hours, for a period of three weeks.

The group will provide a safe environment for members to share their experiences with other children who have also lost their parents. The children will make memory boxes during these sessions. These boxes will be used to keep the mementos, of their parents, that they have or that they create during the sessions.

The sessions will be taped in order to evaluate the effectiveness of the groups. We believe that this will be a healing experience for the children and an opportunity for childline to conduct research.

Your consent is requested, in order for Thandeka Madonsele to attend the Group Play Therapy sessions. Please sign the attached consent form and send it with Thandeka to the first group session.

Yours sincerely

Faye Gough  
PLAY THERAPIST

Toll Free Number: 08 000 55555 P O Box 32453, Braamfontein, 2017  
Tel: (011) 645 1000 Fax: (011) 645 2525 [www.childline.org.za](http://www.childline.org.za)  
E mail: [info@childline.org.za](mailto:info@childline.org.za) NPO No: 043 015 NPO

childline patrons: the most reverend desmond m. tutu, o.m.s.g.d.d. i.k.e. anglican archbishop emeritus of cape town, and mrs leah tulu.  
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management committee: rose motene (chairperson), oscar lockwood (vice-chairperson), doretha moephah (treasurer), murali farren, clive fletcher,  
gugu nkomo, digby jennings, jonathan parkinson, lynne cowood (director), annette brumshu (assistant director).



## 6.1.2 Piers–Harris children’s self-concept scale

<p>1. My classmates make fun of me. .... yes no</p> <p>2. I am a happy person. .... yes no</p> <p>3. It is hard for me to make friends. .... yes no</p> <p>4. I am often sad. .... yes no</p> <p>5. I am smart. .... yes no</p> <p>6. I am shy. .... yes no</p> <p>7. I get nervous when the teacher calls on me. .... yes no</p> <p>8. My looks bother me. .... yes no</p> <p>9. I am a leader in games and sports. .... yes no</p> <p>10. I get worried when we have tests in school. .... yes no</p> <p>11. I am unpopular. .... yes no</p> <p>12. I am well behaved in school. .... yes no</p> <p>13. It is usually my fault when something goes wrong. .... yes no</p> <p>14. I cause trouble to my family. .... yes no</p> <p>15. I am strong. .... yes no</p> <p>16. I am an important member of my family. .... yes no</p> <p>17. I give up easily. .... yes no</p> <p>18. I am good in my schoolwork. .... yes no</p> <p>19. I do many bad things. .... yes no</p> <p>20. I behave badly at home. .... yes no</p> <p>21. I am slow in finishing my schoolwork. .... yes no</p> <p>22. I am an important member of my class. .... yes no</p> <p>23. I am nervous. .... yes no</p> <p>24. I can give a good report in front of the class. .... yes no</p> <p>25. In school I am a dreamer. .... yes no</p> <p>26. My friends like my ideas. .... yes no</p> <p>27. I often get into trouble. .... yes no</p> <p>28. I am lucky. .... yes no</p> <p>29. I worry a lot. .... yes no</p> <p>30. My parents expect too much of me. .... yes no</p> <p>31. I like being the way I am. .... yes no</p>	<h3 style="text-align: center;">The Way I Feel About Myself</h3> <h2 style="text-align: center;">PIERS-HARRIS 2</h2> <h3 style="text-align: center;">AutoScore™ Form</h3> <p style="text-align: center;">by Ellen V. Piers, Ph.D., Dale B. Harris, Ph.D., &amp; David S. Herzberg, Ph.D.</p> <p style="text-align: center;">Published by <b>WESTERN PSYCHOLOGICAL SERVICES</b> <b>wps</b> 12031 Wilshire Boulevard Los Angeles, CA 90025-1251 Publishers and Distributors</p> <p>Client's Name (or ID #): .....</p> <p>Today's Date: ..... Age: .....</p> <p>Gender: (circle one) Female Male Grade: .....</p> <p>School: .....</p> <p>Teacher's Name (optional): .....</p> <p>Race/Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Other</p> <h3 style="text-align: center;">Directions</h3> <p>Here are some sentences that tell how some people feel about themselves. Read each sentence and decide whether it tells the way you feel about yourself. If it is <i>true</i> or <i>mostly true</i> for you, circle the word <i>yes</i> next to the statement. If it is <i>false</i> or <i>mostly false</i> for you, circle the word <i>no</i>. Answer every question, even if some are hard to decide. Do not circle both <i>yes</i> and <i>no</i> for the same sentence. If you want to change your answer, cross it out with an X and circle your new answer.</p> <p>Remember that there are no right or wrong answers. Only you can tell us how you feel about yourself, so we hope you will mark each sentence the way you really feel inside.</p> <p style="text-align: center;">Copyright © 2002 by Ellen V. Piers and Dale B. Harris. Not to be reproduced in whole or in part without written permission of Western Psychological Services. All rights reserved. Printed in U.S.A.</p> <p style="text-align: center;">W-388A</p>
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- |   |     |    |
|---|-----|----|
| 32. I feel left out of things. ....                             | yes | no |
| 33. I have nice hair. ....                                      | yes | no |
| 34. I often volunteer in school. ....                           | yes | no |
| 35. I wish I were different. ....                               | yes | no |
| 36. I hate school. ....   | yes | no |
| 37. I am among the last to be chosen for games and sports. .... | yes | no |
| 38. I am often mean to other people. ....                       | yes | no |
| 39. My classmates in school think I have good ideas. ....       | yes | no |
| 40. I am unhappy. ....  | yes | no |
| 41. I have many friends. ....                                   | yes | no |
| 42. I am cheerful. ....   | yes | no |
| 43. I am dumb about most things. ....                           | yes | no |
| 44. I am good-looking. ....                                     | yes | no |
| 45. I get into a lot of fights. ....                            | yes | no |
| 46. I am popular with boys. ....                                | yes | no |
| 47. People pick on me. ....                                     | yes | no |
| 48. My family is disappointed in me. ....                       | yes | no |
| 49. I have a pleasant face. ....                                | yes | no |
| 50. When I grow up, I will be an important person. ....         | yes | no |
| 51. In games and sports, I watch instead of play. ....          | yes | no |
| 52. I forget what I learn. ....                                 | yes | no |
| 53. I am easy to get along with. ....                           | yes | no |
| 54. I am popular with girls. ....                               | yes | no |
| 55. I am a good reader. ....                                    | yes | no |
| 56. I am often afraid. ....                                     | yes | no |
| 57. I am different from other people. ....                      | yes | no |
| 58. I think bad thoughts. ....                                  | yes | no |
| 59. I cry easily. ....  | yes | no |
| 60. I am a good person. ....                                    | yes | no |

## 6.2 References

African Focus Bulletin, 16 Feb 2006. [www.africafocus.org](http://www.africafocus.org)

AIDS foundation SA. 2005. South Africa: AIDS Statistics. [www.AIDS.org.co.za/hiv.htm](http://www.AIDS.org.co.za/hiv.htm)

Blom, R. 2004. Handbook of Gestalt Play Therapy – Practical guidelines for child therapists. Bloemfontein: Dr Rinda Blom.

Brier, R. 2000. The Gestalt Reflecting Team, A model for advanced training. Gestalt Vol.4No 3. <http://www.g-g.org/gej/4-3/reflectteam.html> (2 Feb 2004).

Carroll, F & Oaklander, V in O'Connor, K & Braverman, L.M. 1997. Play therapy theory and practice; A comparative presentation. New York: John Wiley & Sons, INC.

Chazan, S. 2002. Profiles of play: assessing and observing structures and processes in play therapy. London: Jessica Kingsley Publications.

ChildrenFIRST. October 27, 2003. Memory boxes to help say goodbye. [www.childrenfirst.org.za](http://www.childrenfirst.org.za)

Clarkson, P. 2000. Gestalt counselling in action. London: Sage publications.

Crossley, M.L. 2000. Introducing Narrative Psychology: Self, trauma and the construction of meaning. Philadelphia: Open University Press.

Curran, K.M, Seashore, C.N, Welp, M.G. 1995. Use of self as an instrument of change. The 1995 ODN National Conference, Seattle Washington, Nov 1995, [http://www.equalvoice.com/use\\_of\\_self.pdf](http://www.equalvoice.com/use_of_self.pdf) (10 Feb 2004).

Dane, B O. in Webb, N.B. 2002. Helping bereaved children: A handbook for practitioners 2<sup>nd</sup> ed. New York: Guildford Press.

Dalton, J., Elias, M. & Wandersman, A. 2001. Community Psychology Linking Individuals and Communities: Wadsworth.

de Vos, A.S, Fouche, C.B, & Venter, L in De Vos, A.S, Strydom, H, Fouche, C.B and Delport, C.S.L. 2004. Research at grass roots 2<sup>nd</sup> ed. Pretoria: Van Schaik Publishers.

de Vos, A.S, Strydom, H, Fouche, C.B and Delport, C.S.L. 2004. Research at grass roots 2<sup>nd</sup> ed. Pretoria: Van Schaik Publishers.

Denis, P, Hlabisa, C, Magwaza, B, Makiwane,N, Mitchell, C & Towell, E. 2002. Sinomlando Project: Sharing family stories in times of AIDS – pilot study report. Pietermaritzburg: School of Theology at University of Natal.

Denis, P. 2004. Enhancing resilience in times of AIDS - The memory box programme of the university of KwaZulu-Natal. AIDS Bulletin - June 2004 Vol.13,No2: Medical Research Council of South Africa.

Denis, P. 2001. Sharing family stories in times of AIDS: pilot study report: University of Pietermaritzburg.

Doka, K. 1995. Children mourning, mourning children. Washington: Hospice foundation of America.

Doka, K in Webb, N.B. 2002. Helping bereaved children: A handbook for practitioners 2<sup>nd</sup> ed. New York: Guildford Press.

Dorrington, R. Bradshaw, D & Budender, 2002. HIV/AIDS profiles in the provinces of South Africa. Cape Town: Centre for Actuarial Research. University of Cape Town.

Geldard, K & Geldard, D. 2002. Counselling children: A practical introduction. London: Sage publications.

Ghosh, J. & Kalipeni, E . in Kalipeni, E. HIV and AIDS in Africa beyond epistemology. 2004: Blackwell Publishing Ltd: Cornwall.

Hook, D., Watts, J. & Cockcraft, K. (Eds). 2002. Developmental Psychology. Lansdowne: UCT Press.

Housten, G. 1993. Being and belonging: group, intergroup and Gestalt. Chichester: John Wiley & sons LTD.

IRINnews.org. Monday 21 March 2005. South Africa: child welfare system leaves many AIDS orphans stranded. [www.irinnews.org](http://www.irinnews.org)

Jacobs in Pharoah, R. 2004. A generation at risk? HIV/AIDS vulnerable children and security in Southern Africa. Pretoria: Institute of Security Studies.

Jewitt, L. 2001. ChildrenFIRST. October 27, 2001. Building resilience and hope for the future. [www.childrenfirst.org.za](http://www.childrenfirst.org.za)

Joyce & Stills, 2001. Skills in Gestalt counselling and psychotherapy. Oxford: Sage Publications LTD.

Kalipeni, E. 2004. HIV and AIDS in Africa beyond epistemology. Cornwall: Blackwell Publishing LTD.

Kaduson, H.G & Schaefer, C.E. 2000. Short-term play therapy for children. New York: The Guilford Press.

Latner, J. 1992. Contact boundary disturbances. The association for advancement of Gestalt therapy: <http://www.aagt.org//contact-boundary-disturbances.html>.

Lampert, R. 2003. A child's eye view: Gestalt therapy with children and adolescents and their families. New York: Gestalt Journal Press.

Landreth, G. 1991. Play therapy: the art of the relationship. Bristol: Accelerated Development Inc.

Landreth, G. 1982. Play therapy. Springfield : Charles Thomas.

Lewis, C.S. 1952. Mere Christianity. New York: Macmillan.

Louw, D.A. 1998. Human development. Pretoria: Kagiso.

Louw, D.A, van Ede, D.M and Louw, A.E in Louw, D.A. 1998. Human development. Pretoria: Kagiso

McAdams, D.P. 1993. The stories we live by: personal myths and the making of the self. New York: Guilford.

Mchahon, L. 1992. The handbook of play therapy. London: Routledge.

Mckay, P. April/May 2002. childrenFIRST: Invest in families for the sake of children. [www.chilrenfirst.org.za](http://www.chilrenfirst.org.za)

Meyer, W, Moore, C & Viljoen, H . 2002. Personology: from individual to ecosystem. Third edition. Cape Town: Heinemann.

Morgan, J. 2001. Boxes and remembering in times of AIDS: A story told by Jonathan Morgan in Living Positive Lives, Dulwich Centre Journal, 2000, no 4.

Mussen, P.H, Conger, J.J, Kagan, J & Huston, A.C. 1984. Child development and personality sixth edition. New York: Harper and Row.

Oaklander, V. 1979. Windows to our children: A Gestalt therapy approach to children and adolescents. Moab: Real People Press.

Oaklander, V. 1988. Windows to our children: A Gestalt therapy approach to children and adolescents. Highland, NY: Gestalt Journal Press.

Oaklander, V. 1999. The relationship of Gestalt therapy to children. In The Gestalt Journal, vol V, No. 1, p.64-74.

O'Connor, K & Braverman, L.M. 1997. Play therapy theory and practice; a comparative presentation. New York: John Wiley & Sons, INC.

Perls, F.S. 1971. Gestalt therapy verbatim. New York: Bantam.

Perls, F.S., Hefferline, R.P., Goodman P.1951. Gestalt therapy, excitement and growth in the human personality. New York: Julian Press Inc.

Pharoah, R. 2004. A generation at risk? HIV/AIDS vulnerable children and security in Southern Africa. Pretoria: Institute of Security Studies.

Piers, E.V, Herzberg, D.S. 2005. Piers-Harris children's self-concepts scale; 2<sup>nd</sup> edition; Manual. Los Angeles: Western Psychological Services.

Positive people: 2001. Managing HIV/AIDS in the workplace and community. Arcadia: Kagiso Education.

Richter, L. August/September 2001. ChildrenFIRST: Beyond AIDS Orphans. Slipping through the safety net. [www.childrenfirst.org.za](http://www.childrenfirst.org.za)

Santrock, J.W. 1992. Life-span development 4<sup>th</sup> edition. New York: Wm.C.Brown Publishers.

Santrock, J.W. 2003. Psychology 7. Boston: McGraw-Hill.

Schoeman, J.P. 2001. Centre for play therapy and training. Synopsis: Play Therapy.

Schoeman, J.P & van der Merwe, M. 1996. Entering the child's world: A play therapy approach: Kagiso.

Schoeman, J.P in Schoeman, J.P & van der Merwe, M. 1996. Entering the child's world: A play therapy approach : Kagiso.

Shisana ,O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, K., Bhana, A., Connally, C., Jooste, S. & Pillay, V. 2005. South African HIV prevalence, HIV incidence, behaviour and communication survey. [www.hsrbpress.ac.za](http://www.hsrbpress.ac.za)

Strydom, H. in De Vos, A.S, Strydom, H, Fouche,C.B and Delport, C.S.L. 2004. Research at grass roots – Second edition. Pretoria: Van Schaik Publishers.

Thomas, M.T. 2001. Recent theories of human development. London: Sage publications.

Thomas, R.M. 1992. Comparing theories of child development 3<sup>rd</sup> edition. Belmont: Wardsworth Publishers.

Thompson, R. A. 2003. Counselling techniques 2<sup>nd</sup> edition. New York: Brunner-Routledge.

Van Dyk, A. 2005. HIV/AIDS care and counselling: A multidisciplinary approach. South Africa: Pearson Education.

Webb, N.B. 2002. Helping bereaved children: A handbook for practitioners 2<sup>nd</sup> ed. New York: Guildford Press.



Weiten, W. 2001. Psychological themes and variations. 5<sup>th</sup> Edition. Stamford: Wadsworth.

Yontef, G.M. 1993. Awareness dialogue and process - Essays on Gestalt therapy. New York: The Gestalt Journal Press, Inc.